

**BARRIERS TO MEN'S INVOLVEMENT IN ANTENATAL AND  
POSTNATAL CARE IN BUTULA SUB-COUNTY, WESTERN KENYA**

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## DECLARATION

This thesis is my original work and has not been submitted for a degree in any other university.

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This thesis has been submitted for examination with our approval as the university supervisors.

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## **DEDICATION**

This thesis is dedicated to the following people who played special roles in both my social and academic life. My dear parents, Anthony Akwomi and Petronilla Auma, for sacrificing all the luxuries of life to finance my academic pursuits and instill discipline and other moral values in me that have enabled me reach this level in life. To my dear wife Maureen, my siblings, Bornway, Lydia, Carolyne, Stephen, Vincent, Godwin and Vivian, and my extended family members, notably, my uncle and aunt, Christopher and Francisca, for their moral support and the encouragement that they have unrelentlessly given to me especially in my low moments. To my mentor, Dr. Ferdinand Okwaro, whose encouragement and support has been immeasurable, and finally, to my friends, and my classmates, Henry, Joyce, and Joan, whose endless support and marvelous ideas in the process of writing this thesis have been unquantifiable.

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## **ABSTRACT**

This study sought to explore the barriers to men's involvement in antenatal and postnatal care in Butula sub county, western Kenya. It was guided by the health belief model to ascertain male involvement in ANC and PNC and address the cultural, economic and health facility-based barriers to men's involvement in antenatal and postnatal care. The descriptive nature of the study allowed for the collection of both quantitative and qualitative data. A sample size of 96 men was selected randomly to participate in the survey. Four FGDs and four KIIs were also conducted. The study found out that men accompanied their partners to the clinic, helped with household chores, financed visits to clinics, provided food, and physically examined their families' health. Significant barriers to men's active involvement included cultural factors whereby men viewed maternal health as a woman's domain therefore had some reservations in taking part. Economic factors such as men's nature of work, low income levels, and the expenses incurred while seeking antenatal and postnatal services also came out as key barriers to their active involvement. Whereas health facility-based barriers included the lack of services that directly target men at ANC and PNC, the attitude of healthcare workers, lack of emphasis by healthcare workers on men's involvement, and time spent at the clinic. The study thus concludes that men's active involvement in ANC and PNC is barred to a large extent by cultural, economic and health facility barriers. Therefore, it recommends creation of awareness among men on ANC and PNC, change of attitude among healthcare workers on men's involvement, and a reduction of men's waiting time at the clinic to accommodate their economic life.

## **ABBREVIATIONS AND ACRONYMS**

AMREF	- Africa Medical and Research Foundation
ANC	- Antenatal Care
CHW	- Community Health Workers
CIDP	- County Integrated Development Plan
FGDs	- Focus Group Discussions
HBM	- Health Belief Model
HCW	- Health Care Workers
HIV	- Human Immunodeficiency Virus
IEBC	- Independent Electoral and Boundaries Commission
KIIs	- Key Informant Interviews
NACOSTI	- National Commission for Science, Technology and Innovation
NASCOP	- Nation AIDS and STI Control Programme
PMTCT	- Prevention of Mother-to-Child Transmission
PNC	- Post Natal Care
TBA	- Traditional Birth Attendant
KNH-UoN ERC	- Kenyatta National Hospital-University of Nairobi Ethics Review Committee
WHO	- World Health Organization

## CHAPTER ONE: BACKGROUND TO THE STUDY

### 1.1 Introduction

Antenatal care (ANC) has been used for a long time as a strategy for reducing maternal mortality and enhancing safe deliveries. Postnatal care (PNC), on the other hand, has worked perfectly in reducing infantile mortality when adhered to appropriately. Antenatal care involves the attention, education, supervision and treatment of pregnant mothers from the onset of pregnancy until the beginning of labour. Services offered at this level include vaccination against tetanus, provision of family planning services, HIV testing and counseling and health education among many more. Its main aim is to ensure that there is safe delivery (Nurani and Parker, 2005). Out of these men could benefit from services such as HIV testing and counseling, family planning services and health education. The end of ANC ushers in the start of PNC which involves educating new mothers and supervising them and their infants as well as treating them. At this stage women are reviewed after delivery, they are educated on how to take care of their newborns, their newborns are immunized against diseases such as polio and women are given family planning services. Just like ANC, services such as health education and family planning could benefit men. The main aim at this point is to ensure the wellbeing of the newborn and the mother (Nurani and Parker, 2005).

It has been identified that there are three delay-associated primary causes of maternal death which are delays in seeking care, delay in reaching health facilities and delay at institutional level in providing appropriate care (Nanjala and Wamalwa, 2012:60-67). Therefore, it is important to involve men since some delays that occur can result from women seeking support and permission from the heads of their households who are often men. The types of support women may require from their spouses include need for funds and need to be accompanied to the health facility. Men's involvement would also include support to their wives to prepare for delivery through ensuring that they seek the appropriate medical care during pregnancy, and seek out emergency care where necessary (Singh *et al.*, 2014).

Therefore, men's involvement should seek to address men's own health issues as well as that of their pregnant partners, and their children. If men involvement is well supported by inclusive

health systems, many of them will challenge traditional beliefs that might endanger their partner's health and that of their children (Nurani and Parker, 2005).

Pregnancy and delivery in most cultures of Africa are regarded as the domain of women, and so most men are culturally excluded to accompany their wives to the antenatal care clinics (ANC), for delivery as well as to the postnatal care (PNC) clinics (Mullick *et al.*, 2005). It is also important to note that most societies in Africa are highly patriarchal and therefore most decisions within the families are made by men. Decisions such as when, where and even if a woman should access healthcare, are often made by men. This eventually affects most women's health seeking behaviour as far as accessing ANC and PNC services are concerned (Caldwell, 1986). However, most maternal healthcare programmes exclude men from services and spaces that they could learn about maternal and child health (Akintaro and Olabisi, 2014).

The need for involving and encouraging men to take responsibility for their sexual and reproductive behaviour was discussed in 1994 at the International Conference on Population and Development in Cairo and in 1995 at the Fourth World Conference on Women in Beijing. It was noted that men are in a position of changing attitudes and practices through their positions as heads of homes, as well as religious and community leaders. In addition, by the fact that they are fathers as well as husbands, they should take responsibility for reproductive health issues (Kwambai *et al.*, 2013).

According to Nanjala and Wamalwa (2012), the low involvement of men in ANC and child birth activities is as a result of their lack of knowledge of the complications associated with delivery. In addition, the fees charged at the health facilities for services such as delivery, immunization and family planning, cultural beliefs and uncooperative health workers are other issues that contribute to men's low participation. Efforts centered on sexual and reproductive health have tried to bring men on board as participants. Services such as family planning and prevention of mother-to-child transmission (PMTCT) of HIV have seen men being accommodated on maternal health issues. If the same is replicated to ANC and PNC it may accrue positive results such as men taking part and benefiting from the health education offered at the clinic and having the appropriate knowledge of taking care of their pregnant partners and their children. Previous studies by Aura (2014) and AMREF (2012), reported low numbers of men countrywide who are actively involved in ANC and PNC. This low involvement could be due to cultural, economic

and health facility-based barriers among other barriers that bar their participation, although there is very little information available to support this. Therefore, there is need for more research in this area (Aura, 2014).

## **1.2 Statement of the Problem**

According to Singh *et al.* (2006), men are in a position to positively influence maternal and child health in several ways and are entitled to the right to access the information they need to protect their own health and that of their family. However, their absence at the ANC and PNC clinics deny them the chance of getting services such as health education, family planning, and HIV testing and counseling, that would be important for them, their spouses and their unborn babies. Men's active involvement in ANC and PNC could make them better understand matters of maternity as well as ensure early and improved health care for the entire family. The knowledge that they would have gotten on ANC and PNC can enable them make informed decisions with their partners and share appropriate health behaviours and care during pregnancy, delivery, and postpartum care. Through well informed decisions, for the wellbeing of their families, men can encourage and support ANC and PNC attendance, reduce their partners' workload during pregnancy as well as ensure that there is availability of good nutrition. They can also assist with birth preparations and provide physical, psychological and emotional support for their wives at home. The involvement of men should not be seen as limited to their participation in clinical services and those matters that require them to accompany their wives to health facilities. Practically, it should include a wide variety of activities that support and protect the health of their wives and children (Singh *et al.* 2006).

In Kenya, there have been several attempts/initiatives to encourage men to actively participate in ANC, childbirth as well as PNC. However, despite all these efforts the initiatives have come with mixed successes and failures probably due to cultural, economic and health facility-based factors. According to a 2014 national report by the National AIDS and STI Control Programme (NAS COP), men's involvement in antenatal and postnatal care is still very low. In the report, men's involvement by region was as follows: Nairobi, 5.2%; Western, 5.3%; Central, 3%; Nyanza, 6.4%; Coast, 3.4%; Rift valley, 4.6%; North Eastern, 2% and Eastern, 6%. On average, men's involvement was 5.1% (NAS COP, 2014). According to the Busia County Integrated Development Plan for 2013-2017 mothers' compliance to ANC was at 91.5%, the involvement

of men in ANC and PNC in Busia County (where Butula sub-county is located) was at 20% by 2010, which is still below despite the fact that it was a bit higher than the national estimates provided by NASCOP (2014). This low rate of men's involvement in ANC and PNC could be influenced by various factors such as economic, cultural and health facility-based barriers which need to be investigated.

Most medical systems, both lay and professional, are not accommodative enough for men to participate actively in routine ANC and PNC. This is because most cultures consider maternal care a feminine thing hence discouraging men from actively participating in related activities. In a traditional setting when a traditional birth attendant (TBA) visited homes to offer ANC services or conduct deliveries men would be excluded from the vicinity even though it was their partners who were being attended to. However, with all this exclusion it is forgotten that men are the decision-makers within the family in most African cultures. Through their decision-making, they often govern behaviours regarding the availability of nutritious food, women's workload and allocation of money, transport and time for women to attend health services.

Men's involvement in antenatal and postnatal care should therefore be looked at as an important component of maternal health. However, cultural, economic and health-facility based barriers among other identified barriers have affected their involvement in ANC and PNC. Therefore, this study sought to investigate the barriers to their involvement in antenatal and postnatal care and was guided by the following research questions:

- i. What is the nature of men's involvement in antenatal and postnatal care in Butula sub-county?
- ii. What are the cultural barriers to men's involvement in antenatal and postnatal care in Butula sub-county?
- iii. What are the economic barriers to men's involvement in antenatal and postnatal care in Butula sub-county?
- iv. What are the health-facility based barriers to men's involvement in antenatal and postnatal care in Butula sub-county?

### **1.3 Objectives of the Study**

#### **1.3.1 Overall Objective**

To explore the barriers to men's involvement in antenatal and postnatal care in Butula Sub-county, Western Kenya.

#### **1.3.2 Specific Objectives**

- i. To determine the nature of men's involvement in antenatal and postnatal care in Butula sub-county.
- ii. To explore the cultural barriers to men's involvement in antenatal and postnatal care.
- iii. To determine the economic barriers to men's involvement in antenatal and postnatal care.
- iv. To determine the health-facility barriers to men's involvement in antenatal and postnatal care.

### **1.4. Assumptions of the Study**

- i. Men of Butula sub-county are in some way involved antenatal and postnatal care.
- ii. Cultural barriers such as beliefs, norms, values and traditions of men hinder their involvement in antenatal and postnatal care in Butula Sub-county.
- iii. Economic barriers such as cost of seeking care, transport and economic activities hinder men's involvement in antenatal and postnatal care in Butula Sub-county.
- iv. Health facility-based barriers such as healthcare providers' attitudes such as set-up of ANC/PNC clinic and the nature of services offered at the clinics hinder men's involvement in antenatal and postnatal care in Butula Sub-county.

### **1.5. Justification of the Study**

This study focused on finding out the barriers to men's involvement in ANC and PNC in Butula Sub-county. ANC and PNC in many communities are mostly reserved for the women especially because they are the ones who are most of the time actively responsible for their pregnancies and their newborns in comparison to their husbands. This study sought to highlight the barriers affecting men's involvement in ANC and PNC. In this way the research will provide information on barriers that hinder men's involvement in ANC and PNC as well as the importance of



including them in the same. Therefore, the kind of information that was generated from this study could be useful to policymakers in influencing policies on maternal health care by coming up with systems that can accommodate men to be active participants of ANC and PNC just like their women counterparts. In addition, the outcome of this study could be used by various stakeholders in the health sector both governmental and non-governmental to design tailor-made interventions in addressing barriers that impede the involvement of men in ANC and PNC. Lastly, the finding of this study will be useful to other researchers and academicians since it has generated information that will contribute to the growing body of knowledge on men's involvement in antenatal and postnatal care and maternal health care in general.

### **1.6 Scope of the Study**

This study was conducted in Butula sub-county in western Kenya in July 2017. It targeted married men who had had children in at least the past one year and who also stayed in Butula sub-county as its potential respondents. The study sought to understand barriers to men's involvement in ANC and PNC. Through this, it collected data on men's levels of involvement in ANC and PNC, men's level of understanding of ANC/PNC services as well as cultural, economic and health-facility based barriers to men's involvement in ANC and PNC. The recruitment of all the participants was done in the four study sites which were four locations each represented by one dispensary that offer ANC and PNC services among the total of eleven dispensaries in the sub-county. The study administered survey questionnaires to men, conducted focus group discussions for men as well as key informant interviews with the health care providers at the antenatal and postnatal care clinics in each dispensary. Single men were not included in the study since the study only targeted men and women who were living with their spouses. The study was descriptive in nature and adopted the health belief model as its guiding theory.

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

Three main limitations were experienced in this study. Considering the fact that the main study participants were men, most of the time they were not available at their households during data collection since they were either in their farms or in their businesses. This was solved by making several visits over the weekend until the expected sample size was achieved. In addition, at the time of data collection, ANC nurses who were the chosen key informants were on strike and

hence unavailable at their work stations. This was solved by contacting them and conducting the interviews in their homes. Lastly, the data collection was done during a highly political month which posed challenges gathering groups for FGDs. This was solved by community health workers who helped mobilize FGD participants and clearly explaining to the community the difference between my work and the political gatherings that were taking place.

### **1.8 Definition of Key Terms**

**Antenatal care-** Any form of care given to women and men during the woman's period of pregnancy at the health centre.

**Cultural barriers-** Factors related to beliefs, norms, values, and traditions which limit men's active participation in antenatal and postnatal care.

**Men-**Refers to married men who had had children in at least the past one year before the study and who were living with their spouses in the same household.

**Health facility-based barriers-** Factors at the health facility including the healthcare providers' attitudes, the space at the facility, and services offered at the antenatal and postnatal clinic.

**Postnatal care** –Any form of care given to men, women and their children after at the health center.

**Service providers-** Refers to healthcare workers at the antenatal and postnatal clinics that attend to the clients in need of antenatal and postnatal care services.

**Economic barriers-** Factors that include direct and indirect costs incurred while seeking antenatal and postnatal services.

**Men's Involvement-** Refers to how men participate in various activities within the framework of ANC and PNC service provision

## CHAPTER TWO: LITERATURE REVIEW

### 2.1 Introduction

This chapter reviews the existing literature on men's involvement in antenatal and postnatal care and describes the theory that guided the study as well as its relevance to the study.

### 2.2 Men's Participation in Antenatal Care and Postnatal Care

In most cultures, family planning, pregnancy and childbirth are regarded as exclusively women's affairs. Generally, most men do not accompany their wives to family planning, antenatal care and postnatal care services and are even not expected to attend the birth of their children. In a 2010 study conducted by Bhatta in Kathmandu, Nepal, on the involvement of males in antenatal care, birth preparedness, exclusive breast feeding and immunizations, there was a reported low rate of men accompanying their partners for antenatal care (ANC) as well as for their children's immunization. In addition, the same study revealed that most of the men's involvement in their partners' pregnancy revolved around helping them with domestic work, financial support as well as provision of means of transport to the ANC clinics and during delivery. According to this study, most men viewed ANC as women's duty whereas others lacked the knowledge of ANC and others were just simply embarrassed to participate in the issue (Bhatta, 2013).

In a similar study conducted in Kwazulu Natal State, South Africa, on involving men in maternity care, it was found that both men and women were positive about the idea of involving men with their partners in maternity health in a number of proposed activities, however, such studies also note that despite the fact that the women were willing to involve their men in other maternal health issues like antenatal and postnatal care, they were less likely to involve them at delivery. In the same study, it was also noted that as much as men generally agreed to accompany their spouses to the clinics there was no guarantee of their participation in consultations and discussion forums that take place there as most of them just sat outside waiting for their spouses to be attended to and later escort them back home. In addition, it was noted that women were less willing to involve their partners in areas such as labour and delivery (Mullick *et al.* 2005).

According to Mullick *et al.*,(2005), in the same study conducted at Kwazulu Natal State, most women expressed a lot of desire for their partners' involvement in all areas of pregnancy because

they could now understand the process better and also nurses would then be able to directly communicate and provide health education to their spouses. In addition, Mullick *et al.*(2005), also noted that women would wish their partners to be involved in their maternal issues at several stages, however, antenatal care, labour and postnatal care were the most desired stages of spousal involvement in maternal health. On the other hand, men also expressed a lot of interest in being involved in their partners' pregnancy and even some had ever accompanied their partners in their last pregnancy. Despite them having accompanied their partners to the clinic they waited outside and did not get access to the consultation rooms and therefore did not know what went on in those clinics especially considering the fact that even their partners did not discuss with them what they were taught or told while in the consultation rooms. On the other hand, Mullick *et al.* (2005) identified long working hours as one of men's major impediment to accompanying their partners to the ANC and PNC clinics. Lastly, another barrier identified for men's active involvement was that most service providers had been socialized to maternity as a woman's issue, and would always tell the partners who had accompanied their wives to the clinics to stand outside and let the woman go in alone (Mullick *et al.*, 2005).

Male involvement in Prevention of Mother to Child Transmission (PMTCT) is as low as that in ANC and PNC. In a study conducted in Southern Ethiopia, it was found that 53% of male partners were involved in prevention of mother to child transmission programme. The latter is even higher than what other studies report in East Africa (Semrau *et al.*, 2005). A study conducted in Kampala, Uganda, reported that the involvement of male in PMTCT was low, at 16% (Sarker *et al.*, 2007). In a similar study in Nairobi, Kenya, it was revealed that male participation in antenatal VCT with their spouses was at 15% which is very low (Tweheyo *et al.* 2010). From these studies the following were coming in as common factors that affect men's involvement in PMTCT: knowledge on PMTCT, age, level of education, knowledge, attitude of healthcare worker and the perception that ANC attendance is a woman's domain (Marelign and Shikur, 2015).

### **2.3 Barriers Affecting Men's Participation in Antenatal and Postnatal Care**

There are various barriers that affect men's involvement in ANC and PNC that have been identified by previous studies. These barriers include; social and cultural barriers, institutional

barriers, and economic barriers among many more. This section covers some of these known barriers.

### **2.3.1 Social and Cultural Barriers to Men's Involvement in ANC and PNC**

In most cultures, research has documented the existence of perceptions that inhibit male participation in ANC. The latter is because most men perceive ANC and PNC as a women's affair. In short, pregnancy and childbirth is a women's domain in most cultures. In some cultures, men seen going for ANC with their wives are looked at as weaklings or even sometimes being jealous and overprotective of their wives (Byamugisha *et al.* 2010).

In a study on 'Barriers of husband's involvement in maternal health care in rural Malawi' by Kululanga *et.al* (2012), both men and women viewed pregnancy and childbirth as the domain of women. In the study, it was noted that both the men and women had been brought up to believe that maternal health services are for women. The findings further revealed that even during delivery, the husbands were not allowed to be near their partners since it was a taboo for men to enter the labour and delivery room. The same study also noted out that men were conspicuously excluded from both the traditional and formal instructions given to expectant women. The elderly women in the study area consider involving men in ANC, PNC and delivery as shameful and foreign culture. In the same study, it was further found out that some men did not actively participate in maternal health care because of the shame they get from other men and the community at large. In addition, some of their women were unwilling to incorporate them in maternal health issues. In another study, JHPIEGO (2001), pregnancy and delivery is viewed as a woman's affair by a majority of men and women and even some men reported having feared to be regarded by their relatives and fellow male colleagues as being "ruled" by their spouses if they are seen taking part in birth issues.

Kululanga *et al.* (2012) noted that jealous is another male involvement barrier in ANC and PNC. In the study they conducted in Malawi, it was reported that husbands would feel jealous if they were to witness the tender care male midwives provided to their wives especially during labour and delivery. According to Kululanga *et al.* (2012), male midwives were kind to the expectant women even to the extent of rubbing their backs during labour an act that most men would not be comfortable witnessing being done to their wives and they may go ahead to stop their wives to go for the clinics, an act that could limit the women's access to health services in future.

### **2.3.2 Socio-economic Barriers to Men's Involvement in ANC and PNC**

In another study conducted by Byamugishya *et al.* (2010) with men whose spouses attended ANC at Mbale Referral Hospital, socio-economic factors were identified as one of the barriers that affected the active participation of men in antenatal care. It was noted that most men could not afford to divide time between going to work to provide food for their families and accompanying their wives to the ANC clinics. The lack of enough transport money for both men and their wives to the ANC clinics was another issue that came up. In addition, the study noted that there were other men who had tight working schedules in their employments hence not finding time to accompany their wives to the ANC and PNC clinics.

Aura (2014) found out in a study she conducted in Athi River that some men could not accompany their spouses to the ANC and PNC clinics because they had to remain behind to take care of the other children. According to this study, the most important thing to the men was to provide financial assistance for their spouses to go to the clinics but not their physical presence. Men did not see how their physical appearance would be useful to their spouses. In the same study, lack of adequate finances for their transport to the health facilities as well as that of their wives was identified as another reason for not accompanying their wives to the clinics.

### **2.3.3 Health Facility-based Barriers to Men's Involvement in ANC and PNC**

These are those barriers that arise from the health facilities. Many men are barred from participating in ANC and PNC because of the way the health services are designed/structured. The following is a brief discussion of some of these barriers within the health facilities that put out men from being actively involved in ANC and PNC.

#### **Traditional Modes of Service Delivery as Barriers to Male Involvement in ANC and PNC**

The traditional mode of service delivery is a major barrier towards male involvement. Most maternal health services are women centered and women oriented in the way they are offered. In most clinics antenatal care and postnatal care commence with group health discussions which most of the time focus on women issues ignoring the men. Some of the discussions even go to the extent of portraying men as perpetrators of poor maternal health and barriers to women's access and utilization of health services (Kululanga *et al.* 2012).

Aura (2014) noted that antenatal health services were perceived as being male unfriendly and hence discouraging men from getting involved. In addition, it was identified that long waiting queues at the clinics was another significant barrier to men involvement in ANC and PNC. Most of the time women often crowd on benches queuing to wait for their turns to be served, this discouraged many men from sitting among the highly feminine crowd.

### **Lack of Privacy for Men as a Barrier to Male Involvement in ANC and PNC**

Aura (2014) also found out that the lack of confidentiality among the health care workers is another issue that made some men not to accompany their wives for ANC and PNC. Most men felt that some health workers may not guard their engagements at the clinics as confidential; this is especially considering the fact that at one point they are required to take HIV tests. So they feared being exposed to the highly judging public.

According to Kululanga *et al.* (2012), the infrastructure in most ANC and PNC clinics is also another issue that could breach the privacy of both the men and women clients. The antenatal and postnatal clinics were described as gendered such that men felt unease to be seen in such feminine places. In addition, the ANC services were offered in open spaces that denied both the women and the men the physical and verbal privacy they deserved. Some clinics were noted to have only curtains partitioning two beds whereas others had waiting benches in open areas which expose anyone sitting on them whereas others were situated right at the door exposing the activities going on inside the clinics. Therefore, apart from men's own privacy, some men opted not to be any close to those clinics in order to provide respect to the women.

### **Lack of Agenda for Men as a Barrier to Male Involvement in ANC and PNC**

Kulungula *et al.* (2012) also found out that lack of agenda for men was another barrier towards male participation. In their study, many men would only accompany their women to the clinics and do nothing thereafter, this is because it was the women who needed the services more and to add on that, there were no services at the clinics that targeted men. Therefore, due to this lack of services for men, they found it prudent to engage in other activities especially those that would generate income instead of wasting their time doing nothing at the clinics. In addition, the lack of clear guidelines on how the service providers at the clinics could actively involve men was another barrier to men's participation. Most health systems have no structured guidelines on how

to engage men in maternal health hence limiting their participation to only escorting their wives to the clinics (Kululanga *et al.* 2012).

#### **2.3.4 Distance from the Maternal and Child Health Clinics as a Barrier to Male Involvement in ANC and PNC**

According to Kululanga *et al.* (2012), the distance of the clinics from the clients' homes is also another reason that makes most men not to accompany their spouses. The further the clinics are from the homes the more the financial requirements to get to the clinics. The latter would mean that either clients' have to walk for several hours or spend a lot of money for transportation to the clinics. Sometimes they also have to eat due to the long journeys they take to access the services and all these involve the use of resources. Therefore, to reduce on the cost, most men find it wise to just cater for the transportation of their wives to the clinics as they remain behind to engage in other activities. The further the distance of the more the time it takes to get to the clinics and this is what most men are avoiding since they do not want to be taken away from their income generating activities for long lest they fail to provide for their families (Kululanga *et al.* 2012).

#### **2.3.5 Lack of Knowledge about Men's Involvement in ANC**

The lack of knowledge also comes in as a barrier sometimes if not most of the time. Some men do not know the importance of their active participation in antenatal and postnatal care; there are those who even do not know that there are services at the ANC and PNC clinics that they could be involved in. In a 2011 study by the AMREF in Busia on determinants of male partner involvement in promoting deliveries by skilled attendants, majority of male partners who were interviewed exhibited very low knowledge regarding the importance of their involvement in maternal health. Majority of them said that delivery is a natural phenomenon and therefore saw no need of being involved. This notion that delivery is a natural phenomenon is a clear indication of their lack of knowledge regarding the complications that are associated with pregnancy, labour and delivery and that from skilled attendants (AMREF, 2011).

Kululanga *et al.*, (2012) noted that most men who missed sensitization campaigns on maternal health care by service providers were never told with their wives on the importance of their involvement in maternal health care. Also most of the sensitization campaigns on maternal health care take place at the health facilities hence leaving out those who do not go to the clinics. Posters on maternal health care are posted on notice boards at the ANC and PNC clinics where



most men don't go. In addition, most seminars and useful discussions on maternal health take place during the ANC and PNC visits during the time when men are busy working in market places, farms as well as other places of work. Most of the time the women who are direct participants are supposed to share the knowledge they get with their spouses but they end up not doing so. Therefore, the latter leaves most men with the lack of knowledge on the importance of their involvement.

## **2.4 Theoretical Framework**

### **2.4.1 Health Belief Model (HBM)**

The study applied the Health Belief Model (HBM) to explore the barriers to men's active involvement in antenatal and postnatal care. The model was first developed in the 1950s by social psychologists; Hochbaum, Rosenstock and Kegels working in the US Public Health Service Department. It was developed in reaction to the failures of public health preventive services at that time and more specifically for explaining and predicting health-related behaviours more so in regard to uptake of health services (Janz and Becker, 1984)

According to Rosenstock (1974), the main argument of the HBM is that a person's belief about health related problems, perceived benefits of actions and barriers to actions as well as self-efficacy explain people's involvement or lack of involvement in health-promoting behaviours. In addition, a stimulus or cue to action is important in triggering health-promoting behaviours.

HBM is known to have eight constructs of which six are primary and two others were added much later. The latter are important components in explaining health seeking behaviours. They are as follows:

**Perceived susceptibility:** This basically explains those factors that influence and motivate people to practice healthier behaviour. These include the beliefs and opinions of individuals regarding the chances of contracting an illness. People who perceive themselves as susceptible to particular health problems will adopt behaviours that reduce their chances of developing the problem (Rosenstock, 1974).

**Perceived severity:** This is how individuals look at the consequences or seriousness that diseases might have on them if actions are not taken. This is highly influenced by their previous

experiences with illness. According to Rosenstock *et al.*, (1988), previous experiences with illness can include assessment of the health as well as social and economic consequences of acquiring a disease.

**Perceived threats:** This component of HBM refers to a combination of factors from perceived susceptibility and the perceived severity component. In health seeking behaviour, people seek care when they perceive a health issue as serious and can have severe effects to their lives. They will continue with care if only there is a perceived threat (Orji, 2012)

**Perceived benefits:** This refers to an individual's own conclusion on the value of engaging in a health-promoting behaviour. It involves the individual's thoughts to whether the new health behaviour is better than the one he/she is already practicing and their assessment of whether the new behaviour will decrease risk to disease (Janz and Becker, 1984).

**Perceived barriers:** These include the evaluations of individuals concerning what would stop them from taking over a new behaviour (Hayden, 2013). People would go to seek care if they are not faced with factors that would disfavor them or stop them. This also applies to compliance to a treatment/health care.

**Modifying behaviour:** This can be understood as the individual's own characteristics that can affect their adoption of new health behaviour. These characteristics may include; one's culture, education, skills, past experiences among many more. The latter, influence perceptions; perceived severity, susceptibility, barriers, threats and benefits (Rosenstock, 1974).

**Self-efficacy:** This component was not originally part of HBM but added much later in 1988 by Rosenstock and others. It was derived from Albert Bandura's social learning theory. It entails individual's own beliefs regarding their capability to successfully practice health behaviours suggested to them, in other words, it is the confidence that exist in one's ability to take action. Self-efficacy is realized when people's perceived benefits outweigh the barriers. Also this component argues that people opt to try new behaviours if only they believe they can do it (Champion and Skinner, 2008).

**Cue to action:** Just like self-efficacy, this one was also introduced much later. These are those things that trigger people's adoption to new health behaviours as well as medication use (Glanz

*et al.*, 2008). According to Janz and Becker,(1984), cues to action can be categorized twice; internal cues to action (for example pain and symptoms which originate from one's own body) and external cues to action (which may include information from the media, health care providers or people closer to you promoting engagement in health-related behaviours).

In short, according to the Health Belief Model (HBM), modifying behaviours, self-efficacy and cues to action directly affect our perceptions of susceptibility, severity, threats, barriers, benefits and eventually our health seeking behaviour.

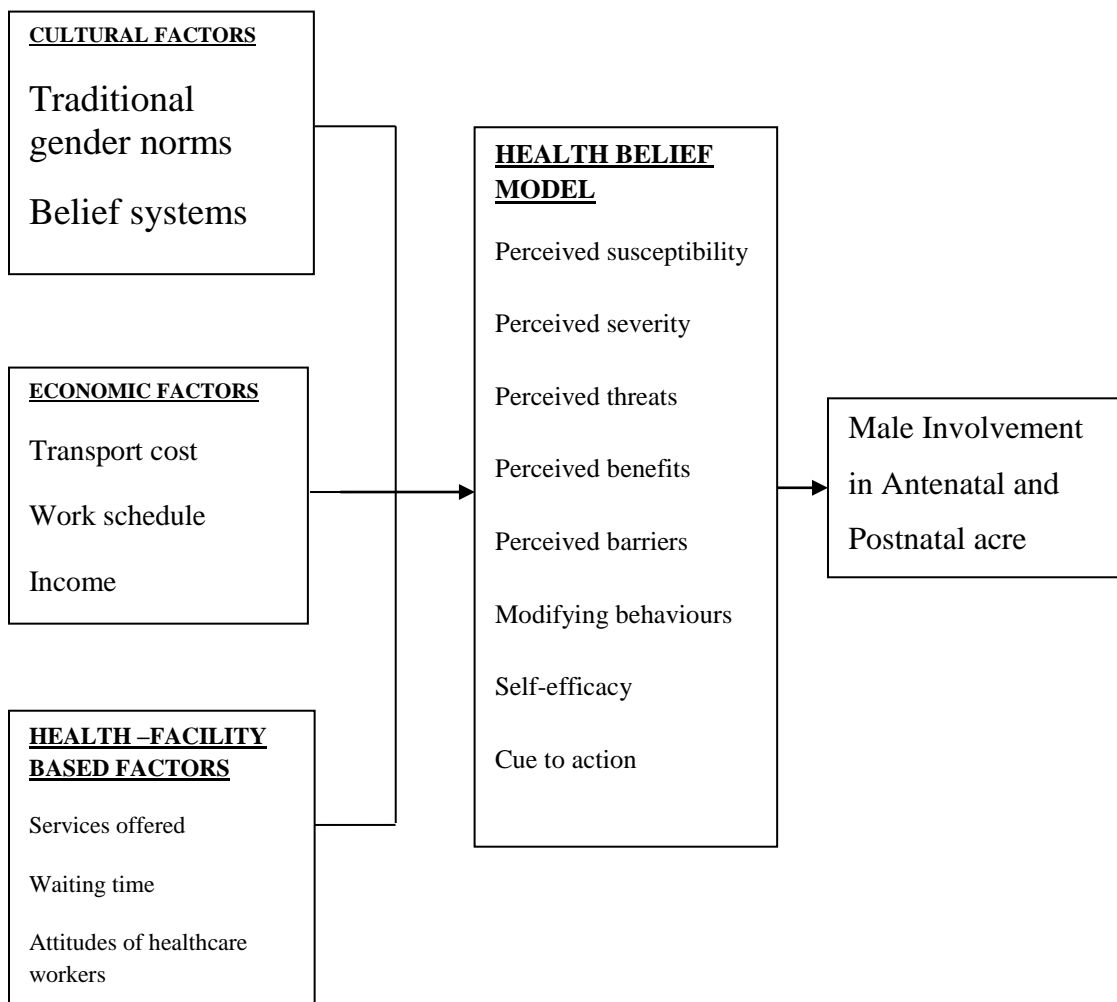
#### **2.4.2 Relevance of the Theory to the Study**

The proposed study sought to specifically find out the barriers to men's active involvement antenatal and postnatal care. Therefore, health belief model (HBM) came handy in guiding it through these specific objectives. This is because when it comes to matters of pregnancy, delivery and childcare, there are various factors ranging from individual's personal beliefs to cultural expectations that could enhance or limit people's participation in maternal health care. This model (HBM) therefore becomes important in guiding the study on some of these issues courtesy of its six constructs. These six constructs in HBM were very resourceful in guiding the study to the end. The concepts of *perceived susceptibility*, *perceived severity* and *perceived threat* create a clear foundation towards understanding how men make decisions, when and to what extent they should actively participate in antenatal and postnatal care. As much as men are not the ones who directly face the consequences of pregnancy they are key stakeholders in the whole process and should hold the same responsibility as their partners in taking care of the pregnancy and the children after delivery. On the other hand, the component of *perceived barriers* was important in informing the two study objectives on the cultural and health facility-based barriers to men's involvement in antenatal and postnatal care. Through this, the study was able to understand how men's perceptions of barriers at the clinic and in their cultures hindered them from actively taking part in ANC and PNC. Also, *perceived benefits* informed the study on some of the values that men thought would come from their involvement in ANC and PNC. This influenced whether it was economically viable to participate in ANC and PNC services or if the benefits of them participating outweighed those they got from their economic activities. On the other hand, the concept of *modifying behaviour* enabled the study understand some of the individual characteristics among men of Butula sub-county that influenced their involvement in

ANC and PNC. In addition, *self-efficacy* in HBM was useful since it captured men’s ability to participate and how they related with the existing barriers. Lastly, *cue to action* which entails the triggers that make people take actions as far as health behaviour is concerned was relevant when looking at some of the triggers that made men to participate in antenatal and postnatal care.

## 2.5 Conceptual Framework

The study looked at the various factors that barred men’s participation in antenatal and postnatal care in Butula sub-county with concentration on cultural factors, economic factors and health-facility based factors; this was guided by the conceptual framework that is in figure. 2.1.



**Figure 2.1: Conceptual framework**

## **CHAPTER THREE: METHODOLOGY**

### **3.1.1 Introduction**

This chapter outlines the overall methodology that was used in the study. It constitutes of a description of the research site, study design, study population, sample population and sampling procedure, data collection methods as well as the data processing and analysis procedures. In addition, it discusses the ethical considerations that were observed before the study, during the study and after the study.

### **3.1.2 Research Site**

This study took place in Butula Sub-county, Busia County (Fig.3.1). Butula Sub-county is located in the Southern part of Busia County bordering Siaya county and Kakamega county and covers a total area of 247.1 sq km with a population of 121,870 people comprising 47% male and 53% female (Kenya National Bureau of Statistics, 2013). According to the 2013-2017 Busia county Integrated Development Plan (CIDP) Butula Sub-county is divided into six locations which represent the six existing wards and has twelve health facilities (GOK, 2013).

Majority of the people living in Butula are Abamarachi (A sub tribe of the Luyia community), however there are other tribes within the county that conduct various businesses. Olumarachi is the major language spoken by the people of this Sub-county, however majority of the locals living at the border of Busia County and Siaya County within the Sub-county have a good command of Dholuo. Swahili and English are also widely used. The main religion practiced by the locals is Christianity with the majority being Catholics and Anglicans (GOK, 2013).

The kinship system of people of Butula is highly patriarchal and therefore the male members of the house are considered as the breadwinners and leaders in most aspects of life. To this regard, roles are culturally defined along gender and the community expects each gender to behave in a particular manner. There are those chores that are assigned to women and therefore men are not expected to take part in them. For example, matters concerning pregnancy and delivery are a reserve of the women with very few men being actively involved. On average people of Butula are well-educated with majority having gone past primary school (AMREF, 2012).

Most of the locals in Butula engage in farming, growing maize, millet, sorghum, beans, and sweet-potatoes among other crops. Sugarcane was the main cash crop but now most farmers have stopped planting it due to the losses they incurred from the low prices they are often offered



Discussion (FGD) consisting of men was conducted per site. These sites were, Marachi East, Marachi North, Marachi Central and Elugulu sub-location. In addition, (KIIs) that involved healthcare workers in charge of ANC and PNC at the selected clinics and community health workers were conducted. Data was collected in three phases where structured interviews were prioritized among 96 male participants in the selected four locations. Through this, the researcher got an opportunity of gaining insights from the structured interviews that informed the qualitative interviews. The second phase followed with men's focus group discussions. Questions asked were designed in such a way that they fill the gaps that were left by the structured questionnaires. The last phase was healthcare worker's key informant interviews that provided an opportunity to capture data from the provider's perspective.

### **3.3 Study Population and Unit of Analysis**

The study population consisted of married men of Butula Sub-county who had at least had children in the past one year before the time of the study, who lived with their spouses in the same household, and were above 18 years of age. These men were selected on the basis that their partners had had children in the past one year and therefore should have had an experience of ANC and PNC in the recent past. The unit of analysis was the individual married man.

### **3.4 Sample Size and Sampling Procedures**

The study took place in 4 wards of Butula sub-county (Marachi East, Marachi North, Marachi Central and Elugulu). These wards were picked from a randomization process that gave all the six wards chances of being picked as study sites. The researcher wrote down on pieces of paper all the six wards in the sub-county and mixed them up and randomly picked four to be the study sites. Later on, 96 men (24 from each selected ward) were selected using the simple random sampling method to respond to the interviews. This sample size was calculated based on a confidence level of 95% and a confidence interval of 10 using Creative Research Systems online sample size calculator tool. The total population of men above the age of 18 and had children was used to calculate the sample. The recruitment of the 24 study participants was done by identifying four health centers with maternal and child health units (MCH) each from one study site as reference points and then men recruited from within households in that particular village where the facility was located. The first household on the right side of the health facility was picked then the rest were randomly picked by simple random sampling to select men for

interviews. Only those who had at least one child born at least one year before the date of the interview were included to take part in the study. The process continued until the right sample size of 24 per site was achieved.

### **3.5 Data Collection Methods**

#### **3.5.1 Structured Interviews**

The main method of data collection was structured interviews which collected quantitative data. A structured questionnaire (Appendix IV) with both closed and open ended questions was administered to 96 men. This method collected data on socio-demographics, the level of men's involvement in ANC and PNC services, the level of men's understanding of ANC and PNC services as well as the level to which cultural, economic and health-facility based barriers affect men's involvement in ANC and PNC.

#### **3.5.2 Focus Group Discussions**

The study conducted four Focus group discussions with men, this was important since it contributed to a better understanding of the involvement of men in antenatal and postnatal care. The FGDs with men were conducted with the aid of a focus group discussion guide (Appendix III) to gather the views of the participants. The FGDs comprised of 6 to 12 participants who were drawn from each of the four study sites. The inclusion-exclusion criteria was that they should be married men and living in the same household with their spouses who are above eighteen years of age and had a child/children in the past twelve months prior to the study date. This method sought to get the general perceptions and beliefs about the barriers to men's involvement in antenatal and postnatal care. The discussions were recorded and later transcribed for analysis.

#### **3.5.3 Key Informant Interviews**

Four key informants were identified for interviews. A key informant interview guide (Appendix IV) was used to collect the data. These key informants consisted of health care workers three Nurses in charge of mother and child health (MCH) services from four selected ANC and PNC clinics and one community health worker working closely with the MCH in the sub-county. The study considered these health care workers resourceful key informants because they are the ones who interact most with the clients who come for antenatal and postnatal services. The Key informants were selected purposively based on the key roles that they played in ANC and PNC. The interviews were recorded and later transcribed for purposes of analysis.



### **3.5.4 Secondary Sources**

During the development of this thesis, secondary sources were involved. Newspapers, journals, books, websites among other sources have been very important in the development of this proposal. The use of secondary sources continued being relevant in the remaining part of the study and complemented other methods of data collection.

### **3.6 Data Management, Processing and Analysis**

Since this is a mixed methods research, both quantitative and qualitative data processing and analysis methods will be used by the researcher. The audio files from FGDs and KIIs and the SPSS data files were saved in password protected folders, whereas the filled questionnaires were stored in secured cabinets after data entry. Data collected from the semi-structured interviews was entered in SPSS. On the other hand, data from the focused group discussions and the key informant interviews was transcribed and translated where necessary. The data was checked for quality issues and cleaned where necessary. Frequencies of the data entered in SPSS were then run and the results used to generate frequency tables and graphs that were used to present the data. On the other hand, data from the focused group discussions and the key informant interviews were transcribed, then the data sorted thematically, summaries made out of each sets of data, and presented in the form of themes guided by the specific objectives backed up with verbatim quotes.

### **3.7 Ethical Issues**

The research sought the necessary license from the National Commission for Science, Technology and Innovation (NACOSTI) as well as ethical clearance from the Kenyatta National Hospital/ University of Nairobi (KNH-UoN) Ethics and Research Committee (P392/07/2017). Informed consent was sought from all participants, and only those willing to give their informed consent by signing a consent form (Appendix I) were recruited for the study. All the participants were also informed about the project and their right to withdraw from participation at any stage, if they wished to. In addition, the study also assured the participants of the confidentiality of the information that they provided and efforts put in place to respect their desires and wishes. Anonymity and privacy for the respondents was observed and the respondents were assured that their names will not be divulged at any point of the study and that the information will only be used for academic purposes.

### **3.8 Dissemination of findings**

A copy of the study findings report will be available at the University of Nairobi library and in the online repository in the form of a thesis. In addition, the study findings will be used to write objective-based research papers that will be submitted to peer-reviewed journals for publication and availed online or in hard copy for students, other researchers and policy makers to access and benefit from the information. The community that took part in the study will also be notified once the findings have been published and those interested to read will be communicated to on how to access the findings once they are published. A copy of this thesis will also be submitted to NACOSTI and KNH-UoN ERC.

## CHAPTER FOUR: NATURE OF MALE INVOLVEMENT IN ANTENATAL AND POST NATAL CARE

### 4.1 Introduction

This chapter reports on the socio-demographic characteristics of the respondents and further discusses what the participants reported as their way of involvement in antenatal and postnatal care.

### 4.2 Demographic Characteristics of the Respondents

#### 4.2.1 Age of the Respondents

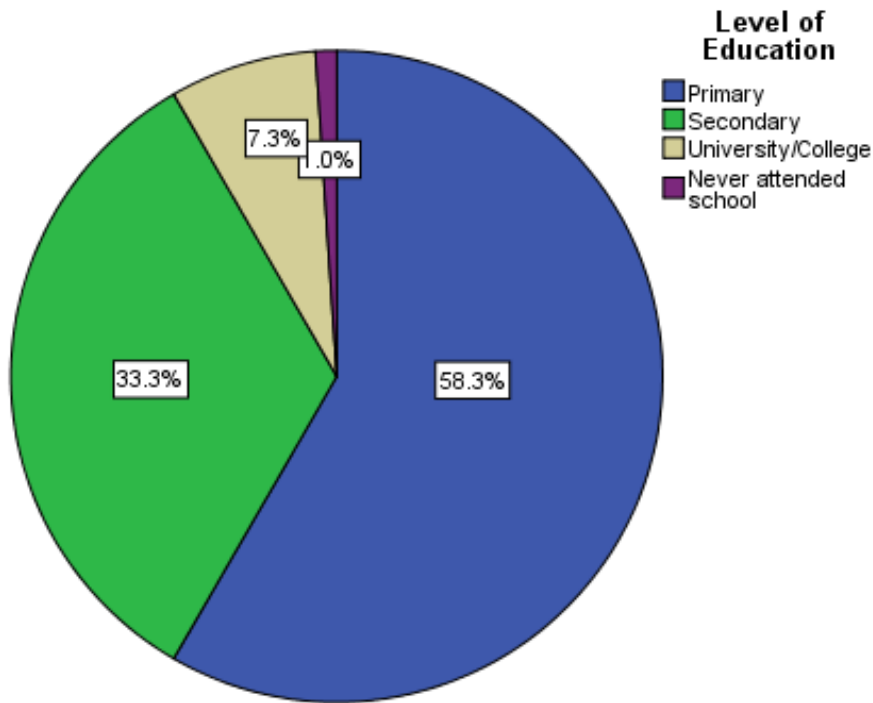
The age of these respondents ranged from 20 to 83 years with an average of 38 years. Majority of the participants (61%) were aged below 40 years. This data is as represented in Table 1.

**Table 1: Age of respondents**

Age	Frequency	Percentage
20-29 Years	26	27
30-39 Years	33	34
40-49 Years	25	26
50+ Years	12	13
<b>Total</b>	<b>96</b>	<b>100.0</b>

#### 4.2.2 Level of Education Achievement by Respondents

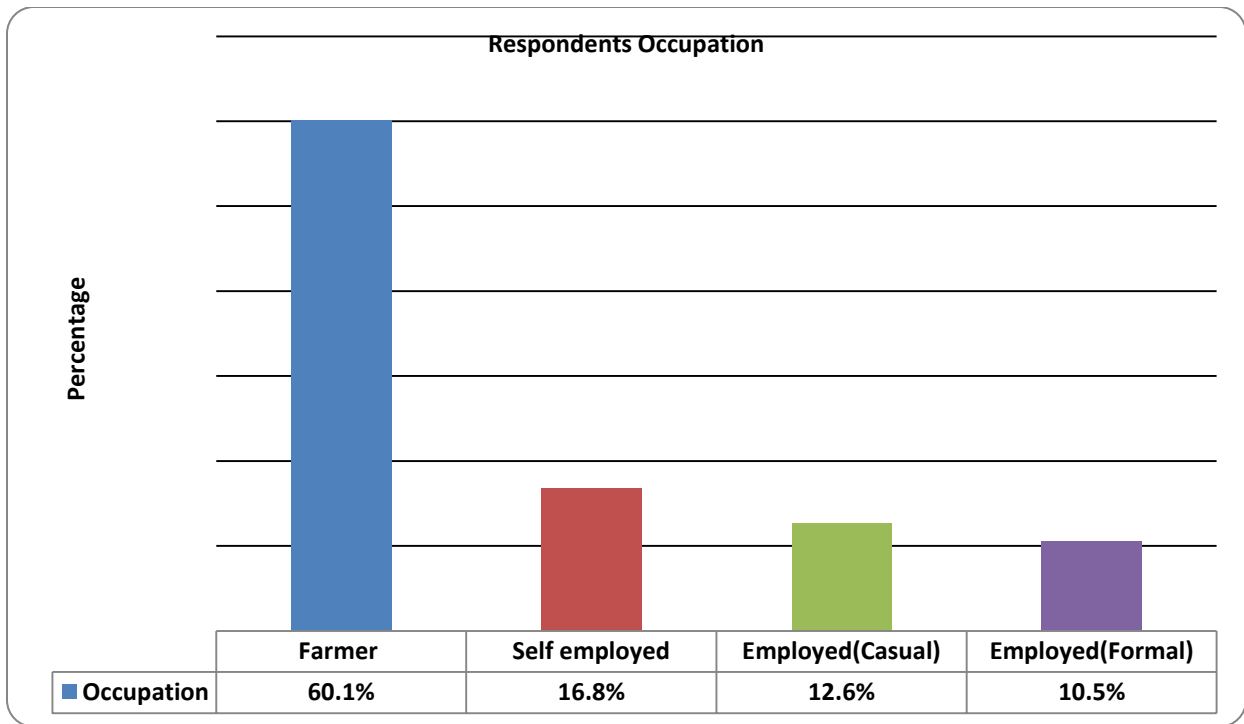
The education level was recorded for all the respondents of the survey. Four levels of education achievement were investigated; these included primary school, secondary school, university/college and never attended school. The findings of this study revealed that majority of the respondents had attended school up to the primary level, this stood at 58.3%. Out of the 96 respondents, 33.3% had secondary education and 7.3% university/college. Only 1.1% had never attended school. The findings are as represented in Figure 4.1.



**Figure 4.1: Highest level of education achieved by respondents**

#### **4.2.3 Occupation of Respondents**

The occupation of the respondents was measured in four categories namely; farmer, employed (casual), employed (formal) and self-employed/Running business. Those who were put under the category of farmers engaged in any kind of farming as a source of their income, employed (casual) are those who worked for other people but not on a permanent basis, employed (formal) are those who were permanently engaged in a formal career, whereas self-employed/business fell under the category of those who were running their personal businesses either in the market place or outside their houses inclusive of *boda-boda* riders. Most of the respondents were farmers (60.1%) while only 10.5% were formerly employed (Fig 4.2).



**Figure 4.2: Occupation of respondents**

#### 4.2.4 Number of Children

The study also sought to find out the number of children that each respondent had. The findings revealed that 53.1% had between 0-3 children, 27.1% had between 4-6 children, 10.4% had 7-9 children whereas 9.4% had more than 10 children (Table 2).

**Table 2: Number of children**

No. of Children	Frequency	Percentage (%)
0-3	51	53.1
4-6	26	27.1
7-9	10	10.4
10+	9	9.4
<b>Total</b>	<b>96</b>	<b>100.0</b>

### 4.3 Men's Involvement in ANC and PNC

The study found out that men's involvement in antenatal and postnatal care was at different levels as expounded on in the subsequent sub-sections;

#### 4.3.1 Accompanying their Wives to the ANC and PNC Clinic

Slightly more than half (55.8%) of the respondents had accompanied their wives to the clinic during antenatal and postnatal visits. There was also consensus in the FGDs where participants reported that they got involved in their partners' ANC and PNC through accompanying them to the clinics. This is as captured in the following quote from an FGD participant from Tingolo: *"When my wife was pregnant, I accompanied her to the clinic four times until that time when she delivered. After she got a baby I have never gone there."* From the FGDs, participants agreed that pregnancy is a critical phase in a woman's life and it was therefore important for their male partners to go with them to ANC and PNC clinics to make sure that they were okay since they were just like sick people. This was as stated by participants from an FGD from Tingolo: *"Once your wife delivers, you should accompany her to the clinic because she is just like a sick person who needs to be taken care of."* The Key informant interviews also reported that men in this region get involved in their partners' ANC and PNC by accompanying their wives to the clinics. This was as reported in the following findings:

*"Most men don't get involved actively in ANC and PNC unless they are just escorting their wives while they are sick during pregnancy and when they get to the clinics, they just leave the women to register as they wait from a far."* (ANC nurse: **Marachi East**)

During these visits that the men had accompanied their partners to the clinics, 50.0% of them joined their partners in the consultation rooms whereas a relatively lower percentage (41.5%) at postnatal visits. This was as put across in the following quote from an FGD participant in Tingolo with consensus from the other participants, *"When my wife was being served at the clinic I had to go in and see what they were doing to her because she is my wife and I am the one who had accompanied her there."* On the other hand, it was noted that few men (33.7 %) joined their partners in group discussions organized at the hospital during antenatal visits while only 31.6% during postnatal visits (Table 3).

**Table 3: Nature of involvement in ANC and PNC**

Nature of involvement in ANC & PNC	ANC		PNC	
	Yes (%)	No (%)	Yes (%)	No (%)
Did you accompany your spouse for ANC/ PNC in her last pregnancy and after delivery?	55.8	44.2	55.8	44.2
Did you accompany your spouse for consultations/counseling during the visits that you accompanied her?	50.0	50.0	41.5	58.5
Did you join your spouse in group discussions during the visits that you accompanied her?	33.7	66.7	31.6	68.4

Despite the fact that quite a good number of men reported that accompanying their partners to the clinic for ANC and PNC was one of their roles, some saw no need of accompanying them when they visited nearby clinics but saw it useful to escort them only when they would visit clinics that were far away from their homes. This is as illustrated below:

*“I have a three year old, during the time that my wife was going to the clinic; I did not see any need of accompanying her because it was just near our home. However, I would have done that if it were somewhere far from our home.” (FGD Participant: Tingolo)*

The study was also interested in finding out how often men accompanied their wives to the antenatal and postnatal clinic during their wives last pregnancy and their frequency of attendance. Most men reported that their wives had attended between two and four visits; this was at 36.5% at ANC and 37.5% during PNC. On the other hand, quite a big percentage (27.1%) reported to have never accompanied their wives at all for antenatal visits, whereas, 38.5% had never accompanied them during postnatal care. In addition, despite the fact that 55.8% reported to have accompanied their wives to the antenatal and postnatal care clinic in their last pregnancy, majority of them had only accompanied them once, this was at 38.5% during ANC and 29.2% during PNC. The latter is very low especially considering the fact that most men (36.5%) reported that their wives had attended ANC between two to four times while another 37.5% had attended PNC between two to four times. According to the national recommendations, women are advised to attend at least four antenatal clinics before they deliver. This is as indicated in Table 4.

**Table 4: Number of visits to the ANC & PNC clinic**

	Times	ANC		PNC	
		Yes (%)	No (%)	Yes (%)	No (%)
In your wife’s last pregnancy, how many times did she attend ANC/PNC?	<b>1 Visit</b>	27.1	72.9	15.6	84.4
	<b>2 to 4 visits</b>	36.5	63.5	37.5	62.5
	<b>More than 5 times</b>	27.1	72.9	32.3	67.7
	<b>Don’t know</b>	9.3	90.7	14.6	85.4
In your wife’s last pregnancy, how many times did you accompany her to the ANC/PNC clinic?	<b>1 Visit</b>	38.5	61.5	29.2	70.8
	<b>2 to 4 visits</b>	25.0	75.0	20.8	79.2
	<b>More than 5 times</b>	9.4	90.6	11.5	88.5
	<b>Never</b>	27.1	72.9	38.5	61.5

Through the focus group discussions, it was noted that despite the fact that men had claimed to have accompanied their wives to the clinic, some of them had not even gone closer to the clinic buildings whereas others just got in the compound and waited for their wives to be attended to as they sat under trees and other sheds away from the main buildings of the clinic. This is as captured in the quote below:

*“If you really love your wife, you are supposed to make sure that she goes to the clinic. Personally, I always make sure that I escort her up to the gate and wait for her from there.”*(FGD: **Bumala B**)

From the Key informant interviews, healthcare providers also reported that mostly they saw men waiting from a far as their partners received the services whenever they accompanied them to the clinics. This was as reported by an ANC nurse in the following quote:

*“Most men come to the clinic with their wives and just wait from far as their wives are being served. After the service, they accompany their wives back home”* (ANC nurse: **Marachi Central**)

It was also noted that some men saw no need of accompanying their wives to the clinic because according to them pregnancy is not a disease hence would rather go to work than accompany them to waste their time at the ANC clinic. The following were the findings:



*“Other men don’t get involved by accompanying their wives to the clinic because they know their wives are not sick and therefore need no help. According to them, going there is just like wasting time instead of going to work.” (Community Health Worker: Marachi North)*

These findings are not unique to our study but have also been noted by other earlier studies conducted on male involvement in ANC and PNC. For instance, Dharma (2013) in a similar study in Kathmandu found that men mostly participate in ANC through accompanying their partners to the clinic despite the fact that they are not actively involved in the services being offered there. In his study, 39.3% of the men interviewed had ever accompanied their partners to the ANC clinic as part of their involvement but had not sat with them in groups for health talks and discussions. To the contrary, some participants said that there was no need of accompanying their partners to the clinics. This was also noted by Aura (2014) in Athi River where men reported that they saw no importance to be physically present at the clinic since they had already facilitated their trips there. In addition, they did not look at it as an emergency case like a disease that needed serious attention by them. Through these findings and those of our study, it is clear that men find accompanying their partners to the ANC and PNC clinic as an important part of their participation in their partners’ and children’s health. However, it is also notable that the lack of involving men in the services offered at the clinic discourages most of them from accompanying their partners to the clinic. It should be noted that men’s presence at the clinic is important for the benefit of their children and pregnant partners because even if they may not get the chance of meeting the healthcare workers there is normally a lot of information at the clinic in the form of posters, fliers, and even health education that they could benefit from.

#### **4.3.2 Helping with Household Chores**

The findings of the study also revealed that men participated in their wives ANC and PNC through supporting them with household chores such as cooking, fetching water, splitting firewood and so on. They said that a pregnant woman and a woman who has newly delivered are weak and should be looked at as sick people who need help, especially with those duties that require them to bend. Majority (72.6%) of the men reported to have helped their wives with household chores at ANC while 70.5% helped them at PNC. There was also consensus from the FGDs as depicted in the following quote:

*“When a woman is pregnant, the work of a man should be to provide for her good food and help her with household chores because most of the time she is always weak. The same should apply after she delivers.”(FGD: Tingolo).*

Other studies have also found out that men help their partners with household chores during the time of their pregnancy and immediately after delivery. For instance, Dharma (2013) reported that 56.2% of the men interviewed had helped their partners with household chores during their last pregnancy and after delivery as part of their involvement in ANC and PNC. In addition, Mahiti *et al* (2017) in Tanzania also established that men considered helping their partners with household chores during the postpartum period as part of the ways that they could be involved in ANC and PNC. According to them, this was a period when their partners needed more physical help from them and therefore they felt obliged to help them with some duties. From these findings together with those of our study, it comes out that most men consider the period of pregnancy to be critical and therefore see the need of helping their partners with chores around the house. In addition, most women are normally still weak after delivery and they take long to recover and this is the opportunity that men take to assist them with such duties as cooking, cleaning the house, washing dishes etc.

#### **4.3.3 Financing Wives' ANC/PNC Visits**

Another role of men during ANC and PNC that came out from the findings of our study was financing their partners' trips to the clinics and meeting the costs of services offered at the clinics. The findings show that 68.4% of the men interviewed reported to have supported their wives through financing their visits to the clinics both during antenatal and postnatal care.

The findings of the focus group discussions also indicated that men largely supported their wives by providing money for transport to the ANC and PNC clinics despite the fact that they did not accompany them during all visits. The following is what they had to say, *"I never used to accompany my wife, but I used to make sure that I have financed her transport to the clinic and any other costs associated with her visit at the clinic."* (FGD: Tingolo).

In addition, there was consensus from the FGDs that financial support by men to their partners was an important component of facilitating their ANC and PNC visits. In the same way, once the money is provided, men saw no need of accompanying their partners to the clinics instead went to work to look for more money to meet other needs:

*"As a man you need to make sure that you have given your wife money to go to the clinic as you go to work and look for ways of getting food for the family."* (FGD: Bumala A)

The Key informants interviewed also reported that they had noted that most men support their partners financially instead of physically being at the clinic. One nurse put it as follows, *"Men*

*participate in ANC and PNC by supporting their wives financially when they come to the clinic.”*

The reason why most men preferred providing financial support instead of accompanying their partners to the clinics was because most of them prioritize going to work. This was as captured in the following quote:

*“Most of the time men would prefer going to work and giving their wives money to go to the clinics. As long as the money is available they see no need of joining them.”* (ANC nurse: Marachi Central)

These findings are similar with other study findings; for instance, Aura (2014) in her study on exploring male attitudes in their involvement in antenatal care in Athi River also found out that men participated in ANC by providing financial support and good nutrition to their partners. According to them, once a man has financed the partner's trip to the clinic and has met the cost of services, then there is no importance of him going to the clinic. In addition, Mahiti *et al* (2017) also found that men considered financing their partners as a major role as far as their participation in ANC and PNC was concerned. In this study conducted in Tanzania, the participants expressed that their main and most important responsibility during ANC and PNC was to meet their family needs which included providing money for transport to the clinics, for food, to pay the house helps among many other needs. On the same issue, Dharma (2013) in Kathmandu also noted that men participate in ANC and PNC by providing transport for their partners. From the study, 30.2% of the men reported that they participated in ANC and PNC by providing bus fare to their partners. Based on our results men's role as providers come out clear as far as their participation in ANC and PNC is concerned. Just like in the community where we conducted our study and many other patriarchal communities of the world, men are known to be the primary breadwinners of their families and are culturally expected to meet the needs of their families which mostly range from providing food, household, meeting medical expenses among many more. Since ANC and PNC are activities that are financially demanding, they are obligated to make sure that they meet the expenses associated with the services offered during that time. Most men would therefore opt to concentrate more on economic activities that would enable them meet the financial needs of their partners during ANC and PNC rather than sitting at the clinics where they are rarely directly engaged.

#### **4.3.4 Providing Good and Healthy Food**

Apart from just accompanying their wives to the clinics, another role that men reported to have played in their partners' and children's health is providing food for them. Across all FGDs, it

was agreed among participants that they found good nutrition as one of the fundamental needs of mothers and children during pregnancy and post pregnancy. Therefore, they made it their primary duty to provide appropriate nutrition to complement the care their partners and children got at the antenatal and postnatal clinics. The following is what they had to say.

*“You are supposed to make sure that you provide good food for the mother and child, after which, you should provide transport for them to the clinic as well as check the clinic appointment booklet to know what services they got while they were there.”* (FGD: **Elugulu**)

One nurse also agreed that most men participate in their partners ANC and PNC by providing good nutrition to them and she put it as follows, *“Men participate through providing good nutrition for their families which consists of mother and children.”* (ANC nurse: **Marachi Central**)

Similarly, a study conducted by Vermeulen *et al.* (2016) in Tanzania also showed that men consider provision of food as a way of involvement in ANC and PNC. In this study, male participants acknowledged providing a variety of healthy food as an integral part of their involvement in their partners’ ANC and PNC. In addition, in a study in Kathmandu, 96.3% of the men interviewed reported that they participated in their partner’s ANC and PNC by providing food (Dharma, 2013). In most contexts and especially the African context, men are normally the primary breadwinners for their families of which they mostly do by ensuring that they provide money to buy food for their families.

#### **4.3.5 Checking their Wives’ and Children’s Health**

In the study, 23.2% of the men interviewed at ANC and 27.4% at PNC reported checking on their wives’ and children’s health as one of the activities they did as part of their involvement in antenatal and postnatal care. There was also consensus in the FGDS on the role of men on checking their wives’ and children’s health. One participant from Elugulu even said that checking on wife’s and children’s health was important to ensure their partners and children do not fall sick. This was reported as follows with consensus from the FGD, *“My role as a man should be to take good care of her and my child so that they should not fall sick.”* In addition, it was agreed in the FGDs that it was important to check on their partners’ health since they were the first to report to the hospital incase their partners and children developed any complications. One participant puts as follows, *“As a man you should check on the health of your wife regularly*

*so that in the event that there is a problem, you should be the first one to report to the doctor.”*

**(FGD: Bumala A)**

Such things as massaging their partners' backs during pregnancy and checking on their children's body temperature among others were some of the way they were involved in maternal and child health care. However, the number of men that had done this was quite low since they considered it as the duty of the healthcare worker. In addition, slightly more than half of the men (54.4%) reported to have accompanied their wives for the immunization of their children as part of their involvement in postnatal care.

Other earlier studies such as Dharma (2013) also noted that men participate in their partners' ANC and PNC by checking on their partners' and their children's health. Just like Dharma (2013), in our study men who were interviewed reported that they made sure their partners got the necessary vaccinations and treatment during their pregnancy as well as ensured that their children got the recommended childhood vaccines. It is therefore clear that as much as men may not accompany their partners to the ANC/PNC clinics they are known to be regularly checking on their partner's and children's health and referring them to the hospital where possible as part of ensuring their health well-being. Although some of them may not know when their children are unwell due to the lack of experience in the same, they often rely on the knowledge that their partners got during their ANC and PNC visits. As part of their cultural roles to provide safety to the family; both physical and social, they will do all they can to make sure that the members of their families are in good health.

## CHAPTER FIVE: CULTURAL BARRIERS TO MALE INVOLVEMENT IN ANTENATAL AND POST NATAL CARE

### 5.1 Introduction

This Chapter presents the cultural barriers to male involvement in antenatal and postnatal care. Culture defines how people should behave and what they should believe in, what they should do and should not do. Such practices that involve women’s pregnancy and childcare are defined differently in different cultures. In most cultures, matters of maternal and child care are a reserve of the female members of the family, this study therefore sought to investigate cultural barriers to men’s involvement in antenatal and postnatal care. According to the findings, some of the issues that came out as barriers included, the belief that maternal health is a woman’s domain, culturally defined gender-based chores, ANC and PNC clinics being looked at as a space for women among many more. This section expounds on these findings in detail.

### 5.2 Being mocked by other members of the community

The study findings noted that some men were discouraged from being actively involved in ANC and PNC by the fact that they were mocked by other members of their community. Those who reported to have accompanied their wives to the clinics and had been actively involved in duties that were regarded as feminine in antenatal and postnatal care, were considered as less men by their peers. In the study, 72.5% of the men reported mockery by other men as their reason for not actively getting involved in ANC and PNC. Also, another 22.0% reported influence by their parents not to actively participate in ANC as a barrier to their participation in ANC while 20.9% in PNC. This is as shown in the Table 5.

**Table 5: Socio-cultural barriers to involvement in ANC and PNC**

Socio-cultural barriers to men’s active involvement in ANC & PNC	ANC		PNC	
	Yes (%)	No (%)	Yes (%)	No (%)
Being mocked by other men	72.5	27.5	72.5	27.5
Being mocked by family members	24.2	75.8	28.6	71.4
Belief that maternal health is a woman’s domain	24.2	75.8	22.0	78.0
Influence by parents	22.0	78.0	20.9	79.1

These findings are similar to those of Dharma (2013) which showed that men were not comfortable accompanying their partners to the clinic because they would be embarrassed from mocking by their peers. Also in a Tanzanian study, Mahiti *et al* (2017) found that if a man accompanied his partner to the clinic for maternal healthcare services, he risked being perceived as ‘controlled’ by the partner and therefore may end up being criticized or teased by other men in the community. In addition, Aura (2014) also found out in Athi River that men had been discouraged from accompanying their partners to the clinic for fear of being ridiculed by their peers as being jealous and over-protective of their wives. Thus, this kind of stigma associated with male involvement in ANC and PNC comes out clear as a significant barrier that discourage men from active participation in ANC and PNC. Just like the comprehensive care clinics (CCCs) are perceived as spaces for HIV+ people hence discouraging HIV- clients from seeking services there due to the stigma associated with the clinics, the MCH is a space highly regarded as reserved for pregnant women and young children hence discouraging men from going to those clinics. To protect their masculinity, men would tend to avoid engaging in activities that will make their community question their masculinity. Sitting at the clinic among a group of women portrays them as taking part in women’s activity hence risking their status as men in the community. In addition, the fact that most clinics providing maternal and child health services are characterized with crowds of women, most men would be shy since they would feel that they are invading women’s spaces and also risk being associated with the women seated at the clinic by their peers. To prevent such kind of situations from happening, most men would rather keep off from the clinics than go there and face the embarrassment.

### **5.3 Maternal health issues are culturally women’s domain**

The study findings also noted that among the community (Marachi) matters concerning pregnancy and childcare were considered as a domain for the women. Therefore, this discouraged some men from actively taking part. Most of them were limited to financing ANC and PNC visits and providing food for their pregnant wives and children. In the study, 24.2% of the men interviewed blamed this belief as one of the reasons why they had not actively taken part in ANC while 22.0% in PNC. From the focus group discussions conducted, there was consensus that maternal and child health were considered women’s issues in the community and therefore many men were excluded from taking part. This was described as follows:

*“According to the Luhya culture matters concerning children are left for women Therefore, that is why some of us just choose to finance their trips to the clinics instead of joining them.” (FGD: Elugulu)*

It was also widely noted that locally the ANC clinic is referred to as, *kliniki ya wamama* (Women’s clinic) whereas PNC is referred to as, *kliniki ya watoto* (infants’ clinic). This perception made other men to think that the ANC and PNC clinics were a reserve for the women and their infants. One ANC nurse puts it as follows, *“Some of them call the ANC clinic as pregnant women’s clinic and PNC as infants’ clinic. This makes them to only come to the health facility when they are sick, but not to accompany their expectant wives and their infants.” (ANC nurse: Marachi East)*

In addition, the key informants also reported some beliefs that related to men’s involvement in antenatal and postnatal care. One nurse reported that with her experience working in the community, she had noted that most men would not accompany their partners to the labour rooms during delivery since it would lead to prolonged labour which would mean more pain to their partners. She described it as follows:

*“Among the Marachi, I heard a man saying that there is a belief that if a man went to the labour room with his wife, the wife would experience prolonged labor. Since this is something they don’t want to occur, they will tend to avoid accompanying them to the clinic during labor” (ANC nurse: Marachi East)*

A community health worker also reported that it was common for men in the community not to have a birth plan due to the belief that if they did so, their partners might give birth to abnormal children. She puts it as follows, *“There is a belief among this community that if you planned for the birth of your child by buying clothes and such kind of things, there is a likelihood that you will give birth to a child an abnormal child, therefore men avoid making birth plan during ANC” (Community Health worker: Marachi North)*

Mahiti *et al* (2017) also found out culture as a barrier to ANC and PNC in their Tanzanian study, where they found out that most men had been barred from participating in ANC and PNC because in their culture it was considered a woman’s issue. In the study, participants raised the point that they had not been willing to take part in maternal health services since it was uncommon for a man in their community to be seen attending reproductive and child health clinics with their partners which was considered as ‘women’s issues.’ It should be noted that since women are the ones who are directly affected by the medical consequences of pregnancy,



they have no option but to go to the clinics for the recommended checkups. On the other hand, since men are not directly medically affected, there are very few services that target them as compared to those that target women and children giving them a lee way not to actively take part. In Kenya, those clinics are even named mother and child clinic (MCH) leaving out the male figures in maternal and child health, an element that discourages some men from going there since they feel not needed there.

In addition, Nesane *et al.* (2016) in South Africa also found out that men perceived maternal health as a woman's domain and therefore going to the clinic for antenatal and postnatal care should be the duty of women. In addition, since most if not all services offered at ANC and PNC clinics do not directly target men, there is a high likelihood that the clinics will be branded as women's/children's clinic hence discouraging men from making physical presence and benefiting from the services offered there. Their physical absence at the clinic comes in as an impediment to them getting firsthand information about their partners' and children's health hence disadvantaging them. With this notion that maternal health services are women's business most men end up concluding that they do not really have to be at the clinics and their physical presence will therefore have minimal health outcomes to their partners and children.

#### **5.4 Alternative traditional antenatal/postnatal care practices**

It was also noted that men who reported not to have taken part in ANC and PNC in the formal clinic set up relied on alternative traditional modes of care. From the focus group discussions, there was consensus that in the Marachi community, women have an option of going to the hospitals for ANC and PNC or being attended to by a traditional birth attendant. Men reported to have been discouraged from getting involved in their women's pregnancy issues and encouraged to provide food for them. This was as described below by one participant:

*“We are not just supposed to rely on the clinic, because if a woman is pregnant you can also use the services of the traditional birth attendant to make sure that they are taking care of what the doctor did not do, like massaging the woman. However, when these traditional birth attendants are attending to your wife, a man is not allowed close to the place where such services are being offered. They don't like it.” (FGD: Elugulu)*

One key informant reported that most men who opt for traditional services was because they found them more affordable than hospital-based care. However, during those services traditional birth attendants often excluded them by telling them to leave hence limiting their participation. She puts it as follows, *“They like traditional birth attendants because they are less time*

*consuming and they come from their locality therefore making services cheaper as compared to the clinic. At the same time, when the traditional birth attendants come, the men are told to leave.*” Despite the fact that some men reported that their norms, values and belief systems as part of the reason why they had not actively participated in ANC and PNC, it came out clearly through consensus from the focus group discussions that things have really changed and culture is no longer a big deal as far as men’s involvement in ANC and PNC is concerned. There were some men who would still go ahead to get involved despite what their culture previously dictated. This is as described in the following quote:

*“Our fore fathers used to be restricted from accompanying their wives to the clinic by our culture but nowadays things have changed because we now understand the importance of antenatal and postnatal care” (FGD: Bumala B)*

In addition, one FGD participant said that considering the fact that pregnancy occurs within the nuclear family set up, he would not leave culture to influence his family’s health decisions. This was agreed by most of the participants in the Bumala FGDs and was put across as follows, *“Culture as an issue will not stop me from being involved in my wife’s matters of pregnancy because when she is pregnant, it is a family affair not a community affair or a cultural affair, therefore that cannot stop me, those are things of the past.”*

Findings from Tanzania by Mahiti *et al* (2017) also showed the postpartum period as that particular point in time when most men were excluded from care both at home and in the health facilities. The study participants reported that when their partners delivered, there were other women who were tasked with the duty of assisting them and they were generally excluded from most of the activities that took place. In addition, Aura (2014) also found out that men had been barred from being actively involved in maternal health issues by their cultural beliefs. Our study findings show that men were stopped from being around while the traditional birth attendants were attending to their partners, something that was culturally motivated, PNC. The latter is because the traditional birth attendants not only physically attend to the women but also administer their services in accordance with the belief systems surrounding maternity in their communities which most of the time exclude men. This type of exclusion noted by our study and other related studies deny men the chance of knowing what is going on with their expectant partners and their newborns which makes them unsure of when and how they should get involved in ANC and PNC.

## CHAPTER SIX: ECONOMIC BARRIERS TO MALE INVOLVEMENT IN ANTENATAL AND POST NATAL CARE

### 6.1 Introduction

This chapter discusses the economic barriers to men’s involvement in antenatal and postnatal care. In the study, the nature of men’s work, low income levels and expenses associated with antenatal and postnatal care came out as outstanding economic barriers to men’s involvement, these are as discussed below.

### 6.2 Nature of Work

The findings of this study indicated that most men were barred from getting involved in ANC and PNC by their nature of work and their work schedules. Most (71.1%) of the men interviewed said that they were at work during the sessions that they had not accompanied their wives for ANC while 66.7% during PNC. In addition, 16.7% of the men interviewed said that they were at home working during the ANC visits that they missed and 17.8% during the PNC visits that they had not accompanied their partners to the clinics. The findings were as represented in Table 6.

**Table 6: Reason for missing ANC/PNC**

Where were you during the ANC/PNC sessions that you did not accompany your spouse to the clinic?	ANC		PNC	
	Yes (%)	No (%)	Yes (%)	No (%)
At work where I am employed	71.1	28.9	66.7	33.3
At home working	16.7	83.3	17.8	82.2
At home doing nothing	1.1	98.9	1.1	98.9
Had travelled	11.1	88.9	14.4	85.6

Other findings from the survey also reported that 66.0% of the men blamed the nature of their work as hindrances to their active involvement in ANC while 67.0% in PNC. There was even consensus in the FGDs that the nature of work plays a big role in hindering men’s participation in ANC and PNC. This was as described in the following quote:

*“We work in the jua kali industry and we cannot leave our businesses unattended to even for a day because on that day we shall sleep hungry. So, we let them go as we are busy looking for money.” (FGD: Elugulu)*

In addition, there was a lot of consensus from FGDs by men that they considered financial provision to their partners as important towards their contribution to their health and that of their children. Most of them saw accompanying their wives to the ANC and PNC clinic as a missed opportunity to working and providing for their families. This is because most of them reported to be in the *jua kali*/informal sector where they only earned when they reported to work. This was as captured in the following quote:

*“Men must go out there and search for money through work, the same money is what women need while going to the clinic, in this case when we give them money, then our money represents us in the clinic. We have to look for more and there is no time to waste being idle at the clinic.” (FGD: Bumala A)*

Participants reported that work kept them busy and was important since their partners would still go back home from the clinics and expect to get food for them and their children. That is why they had to be at work to meet such needs. This is as reported in the following quote:

*“What makes most of us not to accompany our wives is because we are always busy out there looking for how our wives and children will eat, it will be very disappointing if she came from the clinic and she found that there is no food.”(FGD: Tingolo)*

Similarly, the key informants reported that men mostly missed out on accompanying their partners to the ANC and PNC clinics due to the nature of their work. This is as captured in the following statement by one ANC nurse from Marachi East, *“Men don’t come to the facility because they go to look for funds to support their families at their places of work.”*

Other studies have also earlier found out that men are hindered from active involvement in ANC and PNC by the economic activities that they engage in. For instance, Aura in 2014 reported in her study that men did not actively participate in their partners’ antenatal care because they had been busy at work. The participants in her study reported that they worked on very tight schedules and odd hours that could not give them an opportunity to accompany their partners for maternal health services. In addition, absenteeism from work could lead to loss of employment considering the fact that they did not hold contracts that gave them such benefits as leave days and day offs from work. Thus, economic activities that men get involved in are key determiners on how much they will be involved in activities outside their work especially during the day. The fact that accompanying their partners to the clinic for ANC and PNC is a time consuming activity, most men would prefer to fund their partners to go to the clinic and get updates from them later. In addition, as much as men consider accompanying their partners to the clinic as an

important duty that every man should be proud of, it is worth noting that their economic contribution to their households somehow surpasses all these other contributions hence making most of them to put more effort in providing for their families. The latter could be the reason why men would choose working over accompanying their partners to the clinic.

### **6.3 Low levels of income**

Low level of income was another issue that came out as a factor that hindered men from participating in antenatal and postnatal care. The findings of the survey reported that there were many men who could not get actively involved in their partners' antenatal and postnatal care due to the lack of enough money; this was 68.8% at antenatal and 63.3% at postnatal care table. According to them, most of the time their money was not enough to be used by both them and their wives as transport to the clinic and therefore opted for the women to go alone as the men went to look for more money. This was as reported below:

*“You can have money, but it is not enough for both of you to go to the clinic, so in this case you have just to give her the money to go to the clinic alone.” (FGD: Tingolo)*

In addition, FGD participants reported that their low incomes dictated that they only let their partners to go to the clinic alone as they went to work to look for more money to meet other family needs. This was as described in the following quote:

*“If your wife asks to go to the clinic, the best thing that one can do is to organize for her transport to the clinic, you do not have to accompany her, because you have to go work and look for more money or else people will sleep hungry in that house.” (FGD: Bumala B)*

The Key informants interviewed also reported that due to the lack of enough money men were barred from participating in some aspects of ANC such as coming up with birth plans during their wives' pregnancy. An ANC nurse puts it as follows:

*“There are some things in ANC like birth planning; most men cannot plan the births of their children through saving because of their economic backgrounds. They don't always have the money to do that in advance.” (ANC nurse: Elugulu)*

Findings by Aura (2014) also show that some men are barred from accompanying their partners to the clinic due to the costs incurred at the clinic as well as the transport costs. This could be a clear reason why most of them prefer letting their partners to go alone to the clinic to cut down on the costs associated with seeking these services. In addition, another study by Dharma (2013) conducted in Kathmandu on male involvement in ANC demonstrated that men with higher

income had greater involvement in their partners' antenatal care. From these two findings together with those of our study, men's levels of income come out as a key factor in their involvement in maternal health services. Just like other health services, maternal health services are financially demanding even in those places where they are absolutely free. As much as they may not incur direct costs in seeking ANC and PNC services, such needs as transport to the clinics are pertinent in their physical presence at the clinics. With limited funds, most men would prefer to let their partners use the little money they have to travel to the clinics as they remain behind to look for more. Where they are required to buy drugs for their partners and/or their children, they would give up accompanying them to the clinics so as they transfer their costs of travel to meeting those expenses. People with low incomes will always do all they can to minimize on their expenditure in order to meet their most important needs. In this view, men with low income levels would consider prioritizing their partners and children to go to the clinics since they are the most needed there and are the direct beneficiaries of the services being offered at the ANC and PNC clinics.

#### **6.4 Expenses Associated with ANC and PNC**

Expenses incurred at the antenatal and postnatal clinic was another reason that men reported as to why they were not actively get involved in ANC and PNC. The findings indicated that 67.0% at ANC and 64.9% at PNC were discouraged by some costs related to ANC and PNC that they could not afford to meet. In relation to the costs, men said that when they went to the clinics, sometimes the nurses asked them to buy things that they were not financially prepared to buy such as cotton wool, surgical blades and gloves yet according to them they thought maternal and childcare services were free. On the other hand, they also reported that when they accompanied their wives to the ANC and PNC clinic, on the way, their wives tended to demand that they are bought for some items that they did not have money for. Therefore, such things discouraged them from accompanying their wives to the clinic.

Similarly, Byamugisha *et al.* (2010) in a Uganda study on the determinants of male involvement in the prevention of mother-to-child transmission of HIV found out that some men were discouraged from going to the clinic due to the costs associated with seeking services there. These men just like the participants of our study reported that clinics were far away from their homes and they would spend a lot of money reaching there if they went together with their partners and therefore chose to let their partners to go alone in order to cut down the costs. In

addition, when they went to the clinics they were met with unexpected fees yet they went there knowing that maternal health services are free. Since ANC and PNC attendance is an economic demanding activity, it is evident that low income negatively affects male partner involvement in them. Low income earners already struggle to provide for their families and often do all that they can to cut down on their expenses. Referring to earlier findings of this study, it came out clear that as far as ANC and PNC is concerned, men would prioritize on meeting the costs that directly impact on the health of their partners and that of their children before any other thing due to their limited resources. Therefore, they would rather prioritize on spending their money on catering for their partners' bus fare to the clinics, medication, and paying for the services offered at the clinic than including the costs associated with their physical presence at the clinic. Most of the time they leave their partners to go to the clinics alone and end up missing out on the services that they could have benefited from if they had been present. This absence associated with the expenses incurred while seeking ANC and PNC services come in as a significant barrier to their involvement.

## CHAPTER SEVEN: HEALTH FACILITY-BASED BARRIERS TO MALE INVOLVEMENT IN ANTENATAL AND POSTNATAL CARE

### 7.1 Introduction

The other specific objective of the study was to establish the health facility barriers to men's involvement in antenatal and postnatal care. The findings revealed that there were a number of barriers at the health facility that discouraged men from being involved in ANC and PNC. Such things as the attitude of the healthcare workers, lack of services for men, lack of privacy at the clinic, lack of emphasis by healthcare workers on men's participation in ANC and PNC, time spent at the clinic, among many more came out clearly during the study. The following is a discussion of the findings.

### 7.2 Lack of Services that Directly Target Men

From the findings of the study, it was noted that there were limited services at the antenatal and postnatal clinic that directly targeted men, these services included; HIV testing and family planning services. In fact when asked of services that they had gotten when they accompanied their partners to the clinic 14.7% reported none at ANC whereas 16.0% at PNC. Most of the men (61.1%) reported to have been counseled alongside their wives during ANC whereas 64.9% had been counseled during PNC. In addition, 45.3% got advice from the doctors during ANC visits and 43.6% during PNC visits, while 42.1% got health educations from the health talks at the clinics during ANC and 41.5% during PNC. This is as indicated in Table 7.

**Table 7: Services got at the clinic**

Services got at ANC/PNC	ANC		PNC	
	Yes (%)	No (%)	Yes (%)	No (%)
Counseling	61.1	58.9	64.9	35.1
Advice from the doctors	45.3	54.7	43.6	56.4
Health education	42.1	57.9	41.5	58.5
None	14.7	85.3	16.0	84.0

In addition, from our study, it was found out that 36.2% of the men interviewed were discouraged from going to the clinic for ANC while another 34.4% for PNC due to the lack of



services that targeted them. Further, another 20.1% reported that the kind of activities that took place at the ANC clinic discouraged them from taking part in antenatal care, while 20.2% were also discouraged from taking part in postnatal care due to the services offered at the ANC clinic.

Further findings from the FGDs indicate inconsistency in the services offered at the clinic. Participants reported that sometimes there were some services that they got during their wives' initial visits but had not gotten them in the subsequent visits. This inconsistency discouraged a lot of them from going there. In addition, the participants reported that most of the time they were told to wait from outside the consultation rooms while their partners and children were being attended to and therefore saw no need of going back there during subsequent visits. This is as stated in the following quote:

*“Sometimes when we accompany our wives to the clinic, we end up just being idle at the benches and sometimes we start hovering around the clinic. This makes us to feel like we have wasted our time. And, because we are not engaged in any services whatsoever, such things make most men to see no need of going there since they are not the ones who are going to be served.” (FGD: Tingolo)*

There was consensus in the FGDs that most services at the clinic target women and children leaving out the men. This made them to feel unwanted at the clinic and discouraged from going there for future visits. This was as described below:

*“Most services at the clinic are for women and even if you go there as a man you will get that you are doing a lot of nothing. Even when they are giving nets, most of the time they target the women and children, they don't think about us” (FGD: Bumala A)*

In fact one participant reported that as much as he tried her best to accompany her partner to the clinic, he still ended up being idle. There was agreement among participants of the FGD that this is what most of them went through whenever they accompanied their partners to the clinics. This is what was reported:

*“I made sure that I took her and my baby to the clinic anytime they were supposed to go there from the time of her antenatal care to postnatal care, however, all the time I used to wait from outside.” (FGD: Bumala A)*

Findings from other studies conducted on male involvement in PMTCT and ANC have also noted the lack of services targeting men at the clinic as a key barrier to male involvement in ANC and PNC. For example, Dinzela (2006) in his study on factors influencing male involvement in PMTCT in Zambia noted that 48% of the men who participated in the study

reported that programs had done little to involve men at the ANC clinic. In addition, Mahiti *et al* (2017) also noted in their study that despite the fact that some men reported to have accompanied their partners to the clinics, most of them would sit in their car, waiting for hours as their partners received the services, this was because some of them were not aware of the services which are rendered at the clinic and what was expected of them whereas others claimed that there had been no services that directly targeted them. It is therefore clear that due to the boredom that men get at the clinic for non-involvement or low involvement, most of them get discouraged from going to those clinics. The fact that most ANC and PNC clinics are female-centered and tend to concentrate more on women as the consumers of their services, men going to those clinics feel left out and unwanted by the health systems hence getting discouraged from accompanying their partners. Most of the time, the fact that they are not directly engaged when they are at the clinics, they feel like their presence there is uncalled for and might not consider going back there during the subsequent visits. In this way, this lack of involvement due to the limited or absence of services that directly target men count as a significant barrier to their participation in ANC and PNC. On the other hand, an increase in services that target men could work as a motivator to their involvement in ANC and PNC hence increasing their participation.

### **7.3 Lack of emphasis by healthcare workers on men's involvement in ANC and PNC**

From the focus group discussions, it was also noted that another barrier to men's involvement in ANC and PNC was the fact that healthcare workers do not emphasize on the need of men's active involvement. Unlike in other facilities where clients who come as a couple for ANC or PNC are fast-tracked as an incentive to encourage men's participation, it was noted that most of the health centers had not really bothered about this. In most communities, healthcare workers belong to a profession that is highly respected by community members and therefore stand a chance of influencing men's behaviours in ANC and PNC if they insisted. Men are likely to accompany their partners to the clinics if the healthcare workers there insisted. In this study, men reported that they did not accompany their wives to the clinic because the healthcare workers did not insist. There was consensus in the FGDs as depicted below:

*“There is no emphasis that we should accompany our partners to the clinic and you know I am not the one who is going to get the services, she is the one.” (FGD: Bumala, B)*

*“What makes us not to accompany our wives to the clinic is that the healthcare workers do not insist that we should go with them. Therefore we see no big reason to bother ourselves to the clinic.” (FGD: Bumala, B)*

Morfaw *et al.* (2013), in a study on male involvement in prevention programs of mother to child transmission of HIV also noted that non-invitation to the clinic by the healthcare workers was one of the major reasons why most men do not accompany their partners to the clinic. Similar findings by Dinzela (2006) in Zambia reported that 61.4% of the men would only accompany their partners to the ANC on doctor's invitation. Still in Zambia, Makoni *et al.* (2016) in their study found out that those men who had been invited by a formal letter from the health providers were likely to be involved in ANC unlike those who had not gotten invitation. Just like Morfaw *et al.* (2013), Makoni *et al.* (2016), and Dinzela (2006), in our study, it came out clear that healthcare workers play a crucial role in encouraging or discouraging male partner attendance in ANC and PNC. Most of the time when the healthcare workers invite the men to the clinics they will go due to the trust that they have to those people who are in charge of their health and that of their families. In Uganda, Byamugisha *et al.* (2010) in their study reported that the respondents suggested that through the healthcare workers writing on their partners' next appointment cards that they be accompanied by them, they will have no choice but go to the clinic because it will be one of the requirements for their partners' next appointment. From the findings, it is therefore clear that through formal invitation by healthcare workers to the clinic, there expected a significant increase of the level of male involvement in their partners' antenatal and postnatal care. This would work best if clinics also device ways of directly engaging men who accompany their partners to the clinics by such things as seeing them as couples in clinical rooms, allowing men to participate in health talks and discussions among others. The latter will be important since there would be no value of them being invited to the clinics and yet they are not engaged in what is taking place there.

#### **7.4 Embarrassing questions asked at the clinic**

From the focus group discussions, another reason that men reported for not taking part actively in ANC and PNC especially by accompanying their partners to the clinic is the type of questions that they would be asked at the clinic. The men reported that healthcare workers asked questions that embarrassed them and that they considered private hence making them to fear going there. Such issues as relating to their partners' menstrual cycle, their sexual encounters among others made most men to avoid the clinic since they considered them embarrassing. This was a common experience across all participants of the FGDs and they were as captured in the following quotes:

*“At the clinic, they ask a lot of questions of which I will be embarrassed to be there while they are asking my wife, such questions like; her last menses and the last time we had sex without a condom are some that I cannot withstand as a man and therefore choose not to go there” (FGD: Elugulu)*

*“There is a time I went to the clinic after my wife had delivered and the doctor started asking me whether I use condoms or not, I felt so embarrassed and the next time I went there I did not join my wife in the consultation room.” (FGD: Bumala A)*

Similarly, Byamugisha *et al.* (2010) also found out in their study in Uganda that some men were discouraged from going to the antenatal and postnatal clinics due to the embarrassing questions that they were asked there. In the study, one participant reported having been asked questions that he regarded as personal and private some of which touched on his sexual behaviour of which he had not been comfortable talking about. The type of treatment that men receive at the clinics is highly depended on the healthcare workers’ attitude on their presence there.

In addition, it should be the duty of each and every healthcare worker to create an enabling environment to all clients that come to the clinic be it men or women. Unfortunately, this does not occur all the time as indicated by the findings of our study and those of other studies. Due to the negative attitude of some healthcare workers on male involvement, some end up behaving unprofessional and asking sensitive questions/discussions that end up embarrassing the men. Such kinds of embarrassing moments are known to keep some men away and limit their visits to the clinics as well as how active they will be involved when they accompany their partners there. Most of them would therefore choose to keep off from joining their partners in the consultation rooms whenever they go to the clinic rather than go there and face the embarrassment.

### **7.5 Time spent at the clinic**

Another issue that came out of the quantitative data is the time spent at the clinic; men reported to have been discouraged from accompanying their partners to the clinic due to the time it took for them to be served. This was 38.3% at ANC and 42.6% at PNC. From the FGDs, men reported preference in spending their time at work where they would get money to provide for their families rather than waste it doing nothing at the clinics. They were not patient enough to wait for their partners as they went through all the services before leaving for work. This is as put across in the following quote:

*“There are a lot of things that go on at the clinics that take a lot of time and that is the time that I am required to be working maybe in the farm, or in my business. Therefore time wasting could be another barrier to us.”(FGD: Elugulu)*

The Key informants reported that most of their clinics are understaffed hence making the services to take a very long time. Some men would therefore look at going to the clinic as a time wasting activity and just drop their wives and pick them later as they go to engage in other activities. An ANC nurse in Marachi Central reported that from her experience with men, they are normally not patient enough to wait for services at the clinic and therefore get discouraged from going there. She stated as follows, *“Our clinic has staff shortage and therefore services are not that quick. Men on the other hand are not patient enough to wait, so what they do, they leave their wives and come and pick them up later.”* Another nurse reported that some of the men who accompany their partners to the clinic choose to leave them there due to slow services and come back to pick them later after they are done. This is as captured in the following quote:

*“Being at the clinic sometimes can be very time consuming. Especially our clinics where you get there is only one nurse who is seeing both children and pregnant mothers yet there is a long queue to attend to, this means that it will take quite some time to attend to all the clients. So, men don’t like waiting in such scenarios. They choose to leave and come later when their wives have been seen.” (ANC nurse: Marachi East)*

In an earlier study on maternal health services by Nchimunya (2015), long waiting time at the clinics coupled with concurrent job demand was identified as a contributing factor to low male involvement in maternal health services. Such services as health talks, weighing, group discussions, medical examination take an average of two hours of which most men would not manage to give waiting at the clinic at the expense of the time that they could be at work. Similarly, Aura (2014) noted that the timings of ANC and PNC were not favorable with men’s activities and therefore men lacked the time to be at the clinic. Also, Makoni (2016) found out that men are limited with time due to the various commitments hence not getting time to go to the clinics.

In addition, Byamugusha *et al.* (2010) in their study in Uganda also found out that providers spend a lot of time to deliver services at the clinic hence significantly hindering men’s involvement. These evidences from earlier studies point out waiting time as a significant barrier to male involvement in ANC and PNC. Similarly, our study findings noted that men find clinic time inconveniencing to their activities and therefore choose to continue engaging in their

economic activities. Most ANC and PNC clinics (especially government clinics) have very limited hours of operation that do not accommodate men to accompany their partners after work. In addition some of them have limited staff and therefore take too long to deliver services hence increasing the waiting time. Such things discourage men from going to the clinics especially considering the fact that the services they are waiting do not directly target them. Therefore, perceived delays at the clinic make men to be less likely to be involved in ANC and PNC.

### **7.6 Lack of privacy**

From the focus group discussions, there was consensus that most men are discouraged from accompanying their partners to the ANC and PNC clinics due to the lack of privacy and confidentiality. Men reported that some of the activities in those clinics embarrassed them and the buildings were not private enough for them not to see what was happening inside. This was described as follows:

*“There is a time when I had accompanied my wife to the clinic, and then in a room opposite the benches where we were seated with other men, we saw a woman give birth. All the men seated there had to run away because of the embarrassment that we were faced with.” (FGD: Tingolo)*

Some men reported seeing what was going on in the consultation rooms and even saw women delivering in the corridors of the clinics as stated in an FGD in Elugulu, *“At our dispensary when you go where women deliver from, you will not believe your eyes. That room is just like a corridor and anybody passing can see inside, therefore most of us are always embarrassed to be in such places and would rather choose to wait from under trees or not go there at all.”* To avoid embarrassments that arise from the incidences that result from less privacy at the clinic, some men chose to wait from a far hence missing such important things as health talks taking place at the waiting bay. This is as captured in the quote below:

*“Sometimes when you go to the clinic you find that women are being told to undress for some tests, in such a situation as a man, I will not want to be close there. Such things make most men to stand far from where the services take place.” (FGD: Bumala A)*

The key informants reported that most of their clinics lack appropriate infrastructure hence lacking the capacity to take care of clients' privacy. Due to the improvisation of some rooms to see clients, their privacy and those of waiting clients is sometimes compromised. The following is what she said:

*“Privacy is also another problem, because our waiting bays are not private enough and sometimes we see our clients in rooms directly opposite the waiting bay where those sitting can see whatever is going on, therefore such things discourage men from sitting close by.” (ANC nurse: Marachi East)*

These findings are similar with those of other studies; Nchimunya (2015) in his study in Zambia also identified the lack of privacy as a significant barrier to male involvement in maternal health services. The participants of his study reported that most of their clinics were deprived of infrastructure and mostly characterized with open spaces which compromised on their privacy and posed a challenge to their involvement in maternal health services. Most ANC and PNC clinics are normally characterized with small spaces in corners of the hospitals’ compounds and crowded groups of pregnant women and mothers with their children. It is common to see some of them overflowing to the grounds outside the clinics and waiting under trees. These small spaces compromise the confidentiality of clients while getting services due to limited rooms for service delivery. The lack of enough spaces dictates that services at the clinics go on in the little available spaces which end up compromising on the consumers’ privacy.

In addition, Byamugisha *et al.* (2010) also identified the lack of adequate space as a barrier to confidentiality and privacy that discouraged most men from accompanying their partners to the clinics. From their study, the men reported that they were often faced by embarrassing situations since the clinic spaces were not private enough to conceal what was going on inside clinical rooms. Just like these earlier studies, it came out clear from our study that men are not always comfortable sitting in such places that are less private and would leave them embarrassed. In order to avoid such moments, they would either avoid going to the clinics by not accompanying their partners during their ANC/PNC visits or go there and stand far away from the places where the services are being offered. The latter means that their absence at the clinic or at the places where the services are taking place deny them the opportunity to understand the process and learn how they would be involved in ANC and PNC hence making their involvement to be substantially low.

### **7.7 Lack of Space for men (Profile of the clients/women)**

The lack of space for men in the clinic was another barrier to men’s involvement in ANC and PNC. The participants reported that when they went to the clinic, the number of women there was too much and therefore became difficult for them to sit among such groups. Generally, it was noted that men didn’t like sitting in spaces highly considered feminine. Therefore, some men

reported that they were discouraged from going there because they didn't want to be seen sitting among women and others feared that the women at the clinic would talk about them and therefore intimidate them. This was a common experience among all FGD participants and it was as reported in the following quotes.

*“When I go there and get myself there alone as a man, I will not go back there next time, because I will think that I will get only women there like the last time I was there.”*  
**(FGD: Elugulu)**

*“You can go to the clinic and find that you are the only man there, this has happened to me severally and I started wondering what I had gone there to do yet my fellow men were not there.”* **(FGD: Bumala A)**

*“Sometimes you just going to the clinic make you feel like you are in the wrong place; you will find a lot of women there. It is like wearing a cloth that does not fit you. Why should you go there just to sit yet there is nothing for you?”* **(FGD: Tingolo)**

In Zimbabwe, Makoni *et al.* (2016) also found out that men are discouraged with the fact that the ANC and PNC clinics are generally characterized with a lot of women and children hence making men to feel out of place whenever they are there. The participants of this study reported that they had not been comfortable seating in the groups of women and children yet they were not directly getting the services at the clinic. In addition, some of them reported that seating close to the women somehow made the women uncomfortable and even some reported being mocked by women for sitting among them. The fact that men consider the ANC and PNC clinic as spaces for women and children, hinder their physical presence to those clinics which consequently comes in as a barrier to their involvement in ANC and PNC. This makes them to be always careful not to interfere with those spaces whenever they go there.

On the other hand, as much as their partners' privacy matter, they also highly value their own privacy when they are in those clinics and would do all they can to uphold their masculinity. In the event that the latter is not met, most of them would shy off from going to those clinics hence missing the opportunity of benefiting from the services offered there as well as the chance of getting firsthand information of what happens to their partners and children at ANC and PNC an issue that consequently limit their levels of participation. Unfortunately, considering the fact that most clinics still lack enough infrastructures to accord both men and women their private spaces, they are often mixed. Due to the latter, some men would prefer not going to the clinics where



they would interfere with women’s spaces or going there and waiting from a far which ends up barring their active involvement in ANC and PNC services offered.

### 7.8 Lack of information on the importance of involvement

The lack of information on ANC and PNC among men was another issue that was reported as a barrier to men’s involvement. It was noted that the healthcare workers had not done enough to educate men on their importance in antenatal and postnatal care. Most men reported that they were not actively involved because they did not know; the services that they would benefit from and how their involvement would have added value to the health of their wives and children. In fact when men were asked where they got the information that they had on ANC and PNC only 22.0% reported that they got their information from the clinic. This is as indicated Table 8.

**Table 8: Source of information on ANC and PNC**

Where did you get the information on ANC & PNC that you have?	ANC		PNC	
	Yes (%)	No (%)	Yes (%)	No (%)
At the ANC and/or PNC clinic	22.0	78.0	20.9	70.1
From a community health worker	23.1	76.9	22.0	78.0
From a neighbor	17.5	82.5	11.0	89.0
From partner	37.4	62.6	46.1	53.9

The findings of the focus group discussion showed consensus among participants on the need of educating men on the importance of their engagement in ANC and PNC. Participants felt that if only men were educated on their importance of taking part in ANC and PNC, they would have gotten involved actively. The following are verbatim quotes of their statements which were reported from FGDs with consensus:

*“Men should be educated on the importance of being involved in ANC and PNC. Therefore, once they know the importance of their involvement, they will be able to actively take part in their wives’ antenatal and postnatal health.” (FGD: Bumala B)*

*“Men should be taught about the importance of accompanying their wives to the clinic and getting involved in ANC and PNC. Such forums like this one we have had and even churches, should be used as avenues where men can be educated about their involvement in mother and child health.” (FGD: Bumala A)*

Makoni *et al.* (2016) also found out that low understanding of their importance to getting involved in ANC and PNC among men was a significant barrier as far as their participation is

concerned. From this study, those men who received feedback and health information from their partners on ANC and PNC were more likely to be actively involved compared to those who were not told anything with their partners. Similarly Madzima *et al.* (2010) in their study on the effect of formal written communication on male partner participation in the prevention of mother to child HIV transmission (PMTCT) program in Zvimba district, Zimbabwe also found out that men who knew the importance of ANC and PMTCT were more likely to be involved in ANC and PNC compared to those who did not have any knowledge. Additionally, Mahiti *et al* (2017) in their study also found out that men were left out of active ANC and PNC due to the lack of information. In their study, the participants reported that formal healthcare systems in their country did not advocate for men's participation in reproductive and child healthcare services during postpartum period therefore not making them aware of the importance of their active participation. It is therefore conclusive enough that the lack of knowledge about maternal health issues among men leads to non-participation and creates fear of the unknown among male partners as far as ANC and PNC is concerned. In this way, giving men the information on how they could be involved and why they should be involved is a key determinant in motivating or de-motivating them in getting involved in ANC and PNC. Men would want to get involved in those activities that they consider important to them and their families and the only way they would consider ANC and PNC as important is through being empowered with the knowledge of how their involvement will matter to their children and pregnant partners.

### **7.9 Attitude of health care workers**

As in earlier findings, general attitude of the healthcare workers towards male involvement in ANC and PNC was also noted to be another barrier. Most men were discouraged from accompanying their wives to the clinics due to the way they were addressed by the healthcare workers. They reported that there were some healthcare workers who had not accommodated them in the clinic space and were even sometimes told to wait from a far as they attended to their wives. This was a common experience among most participants of the FGD and was reported as follows:

*“When we accompany our wives to the clinic, sometimes the healthcare workers at the clinic tell us to wait from outside and give them space to do their work; they do not want to see us following our wives in the consultation rooms.” (FGD: Elugulu)*

Some men reported to have tried to go in consultation rooms with their children and partners but were stopped by the health providers. This left them waiting at the benches and missing out on important information being given to their partners. This was as stated as follows:

*“When I went to the clinic to take my lastborn child I was seated at the triage with my wife when our turn to be served reached, she told me to wait at the bench while my wife went in with the baby. So I just had to follow her instructions.” (FGD: Bumala B)*

Such incidences where men are told to wait outside make discourage them from going to the clinics in subsequent visits. Their absence at the clinic denied them the opportunity to learn about ANC and PNC especially through the morning health talks hence limiting their knowledge and their involvement. The findings report that almost 41.5% of the men interviewed had been discouraged from ANC and another 41.5% from PNC involvement due to the attitude of the healthcare workers.

Byamugusha *et al.* (2010) in their study also found out harsh treatment by healthcare workers as one of the factors that discouraged men from going to the clinic. In this study, some men mentioned that they were met with rude and unwelcoming healthcare workers at the clinics that discouraged them from accompanying their partners in the subsequent visits. Most men fear going to the clinics because of the treatment that they would get from health providers and for the fear of being harassed. In addition, as much as men would wish to join their partners in the clinic rooms during service delivery, they are stopped by healthcare workers. It is therefore clear that provider attitude play a critical role in determining the level of male participation in ANC and PNC at the clinic. As much as some men may take the step of accompanying their partners to the clinics, the healthcare providers at those clinics have a lot of power in deciding where they will be involved and how far they will be involved in their partners' ANC and PNC. Just like other services offered at the clinic there are some healthcare providers who have their own beliefs and perceptions on male involvement in ANC and PNC which may either negatively or positively influence male participation.

Byamugusha *et al.* (2010) further found out that men saw no need of accompanying their partners to the clinics because in the previous visits some of them had not been allowed to join their partners in the clinic rooms during service delivery. In the event that the healthcare workers do not believe in male involvement in ANC and/or PNC, there is a high likelihood that he/she will negatively influence the process to leave out men deliberately; this could be by not engaging

them when they are present at the clinic which leaves most men bored/idle hence finding no reason of accompanying their partners' to the clinics during their subsequent visits. In addition, earlier findings of this study indicate that some men had been barred from getting involved in ANC and PNC due to the lack of invitation by the healthcare providers, this is a clear indication of how important the healthcare providers are in influencing their decisions as far as ANC and PNC is concerned.

### **7.10 Stigma associated with HIV**

In the FGDs, men also reported that they feared going to the clinics because they feared to be tested. During antenatal care, it is normally a requirement for women to be tested for HIV and sometimes healthcare workers encourage them to come along with their partners. This is a strategy used to reduce the transmission of HIV from mother to child during and after pregnancy a strategy known as Prevention of Mother to Child Transmission (PMTCT). However, due to the stigma associated with HIV, most people fear taking the test.

Participants reported that they would just prefer letting their partners go to the clinic and whenever they get tested they would share with them the results. This fear makes them to miss going to the clinics hence missing opportunities of getting the services offered there. This was as captured in the following quote:

*“There are those men who fear being tested and therefore just let their wives to go to the clinic alone. We normally tell them to go for the tests when they are pregnant then they come back and tell us the results.”* (FGD: **Bumala A**)

Others reported that as much as they accompanied their partners to the clinics, they would sit far away from the waiting areas for fear of being called in for a HIV test whenever their partners are called in. This was a common experience among all participants of the FGD and is as captured in the following quote:

*“Most men fear going to the clinic because the healthcare workers there ask a lot of unnecessary questions, secondly, some of us fear going there because we fear being tested for HIV. Therefore what we do, we take them to the clinic and sit far away just to wait for them to finish and then we go back home”* (FGD: **Bumala B**)

These findings on men missing out ANC and PNC visits together with their partners do not stand in isolation but were also highly supported by the key informant interviewed. An ANC nurse from Marachi East had the following to say:

*“Men fear to be tested since it is a requirement among our ANC and PNC mothers, a practice to prevent vertical HIV transmission from mother to child during pregnancy and later during breastfeeding. Since we encourage couple testing, men will prefer not to show up for fear of being tested.” (ANC nurse: Marachi East)*

These findings are similar with the findings of other studies such as Buke *et al.* (2004) who found out that men were afraid of being tested for HIV at their nearest clinics due to confidentiality and issues related to stigma. On the same issue, Perez *et al.* (2004) in a Zimbabwe study on prevention of mother to child transmission of HIV also found out that only 2.3% of the men he interviewed had accepted to be tested for HIV during ANC. Men just like other members of the society fear being victims of stigma associated with HIV, this therefore makes some of them to fear accompanying their partners to the ANC clinics since they will be required to take HIV tests. In addition, Byamugisha *et al.* (2010) also noted in their study that those men who feared to disclose their HIV status to their partners were less likely to be involved in ANC and PNC. Such men avoid accompanying their partners to the clinic because they fear being asked to be tested together with their partners. HIV being an issue that is still coupled with a lot of stigma in the society makes many people to fear knowing their status and live not knowing. However, in Kenya, HIV testing is mandatory in antenatal care as a strategy of HIV prevention of mother to child transmission. On this note, women have no option but to take HIV tests unlike their male partners who are only encouraged to. It is therefore conclusive enough that this relationship between HIV and maternal health services is a notable barrier to male involvement in ANC and PNC. And as for the small number of men that test for HIV, it is as a result of provider initiated testing and counseling (PITC) rather than voluntary.

## **CHAPTER EIGHT: SUMMARY OF THE FINDINGS, CONCLUSION AND RECOMMENDATIONS**

### **8.1 Introduction**

This chapter consists of the summary of the key findings, conclusion and recommendations as guided by the findings of the study. The presentation is structured in line with the three specific objectives of the study, which were: to establish the cultural barriers to men's involvement in antenatal and postnatal care, to determine the economic barriers to men's involvement in antenatal and postnatal care, and to establish the health facility barriers to men's active involvement in antenatal and postnatal care.

### **8.2 Summary**

From the findings it was evident that men are not involved in ANC and PNC as they should due to several barriers that the study sought to find out. As much as they supported their partners' visits for ANC and PNC, most of them avoided direct involvement especially in those activities that required them to accompany their partners' to the ANC and PNC clinics. The following is a discussion of the summary of findings based on the outcomes of the study and guided by the specific objectives:

#### **8.2.1 Cultural Barriers to Men's Involvement in Antenatal and Postnatal Care**

Involvement in ANC and PNC is a unique behaviour among people and is associated to their ways of life. People are brought up and socialized in cultural settings that determine the way they will live and culture is what decides what one should do and what one should not do. As far as antenatal and postnatal care is concerned, the study revealed that among the community of the participants' it was highly regarded as women's domain. Therefore, those men who were seen to be actively involved in ANC and PNC were regarded as being involved in feminine duties hence making them loose their masculinity as defined by their culture. The latter comes in as a barrier and makes most men to be careful with how far they get involved in ANC and PNC. In fact, it is clear in the findings of this study that some men were hindered to get involved because they feared being mocked by their peers as well as their family members.

The fact that matters concerning maternity are considered feminine, most men considered to give women space to do what they know best hence limiting themselves to only being active in facilitation in terms of provision of bus fare, paying for ANC and PNC services and providing

food for their families. It was also noted that the existence of alternative traditional services to hospital-based ANC and PNC were a significant barrier to men's involvement. The findings reported that some men had sought services of traditional birth attendants to complement the care they had received in the clinics. These traditional birth attendants who were normally women often instructed them on how far they could engage with their partners at ANC and PNC while referring to their cultural norms hence barring them from being involved in some maternal health activities.

The findings also noted some contrasting opinion from majority of the participant especially in the FGDs. It was clear that despite the fact that culture came in as a barrier to men's involvement in ANC and PNC, it was not to a large extent. According to the findings, things have really changed and the participants' culture has transformed due to education and men therefore did not consider it as a significant barrier to their involvement in ANC and PNC. Men of these days make individual decisions at their family level about the health of their pregnant women and young children as far as deciding to what extent they will be involved unlike in the traditional setup where children and women belonged to the community hence decisions touching on them mostly occurred at a community level in accordance to the cultural beliefs, norms and values. These cultural beliefs, norms and value no longer suffice as far as men's involvement in ANC and PNC is concerned.

### **8.2.2 Economic Barriers to Men's Involvement in Antenatal and Postnatal Care**

The second specific objective of this study was to determine the economic barriers to men's active involvement in antenatal and postnatal care. The findings of this study are clear that men are barred from active involvement in ANC and PNC by their economic ways of life which include; their nature of work, their levels of income, and expenses incurred in ANC and PNC. It was clear that in their community, men are regarded as the main breadwinners of their families and therefore have to fulfill their duties of providing for their families. The latter can only be achieved through working in employment, working in the farm as well as working in own businesses. In the findings it is clear that majority of the men were farmers, followed by casual workers. It is therefore worth noting that their nature of work played a big role in determining their income by the end of the day as well as their availability to actively participate in their partners' ANC and PNC. It was found out that men spend long hours in the farm and their casual

employment hence lacking enough time to actively be involved in ANC and PNC. Their absence at the farm and their places of employment means that they will not get food for their families on that day hence choosing to let their partners take care of ANC and PNC matters actively as they passively participate through providing for them.

In addition, despite the fact that these men work and do farming, their levels of income sometimes is so low that they will not afford to pay bus fare for two to the clinic hence choosing to let their partners go alone. Also, the low levels of income means that they should continue working throughout hence having very limited time to actively participate in ANC and PNC. Lastly, another issue that came out clear was the cost that men incurred as far as ANC and PNC is concerned. Such costs ranged from paying for services at the clinic, buying drugs for their partners' and children, providing good nutrition for their family among many more meant that men have to spend time looking for how to meet those expenses and this can only be achieved through working. Men reported to escorting their partners to the clinic and leaving them there as they went to work to find money that they later sent to them to meet those many costs incurred at the clinic and at home during ANC and PNC.

It is therefore conclusive enough that economic factors play a big role in determining how active men will be involved in ANC and PNC. In the case of this study, it was evident that men's economic lives are a significant barrier to their involvement in ANC and PNC.

### **8.2.3 Health Facility Barriers to Men's Involvement in Antenatal and Postnatal Care**

Another thing that the study sought to establish was the health facility barriers that hindered men's involvement in ANC and PNC. From the findings, several barriers related to the health service delivery system were identified. Men reported that their active involvement in ANC and PNC were discouraged by such things as; lack of services targeting them at the clinics, nature of activities taking place at the clinics, lack of emphasis by the healthcare worker to invoke their involvement, fear of questions asked at the clinic, time spent seeking services at the clinic, lack of privacy, lack of space for men, lack of demand creation on ANC and PNC by healthcare workers, attitude of the healthcare workers towards men among other issues.

According to the findings it is clear that men are not likely to accompany their partners to the ANC and PNC clinic if they are just going there to sit idle and wait for them, most men consider



this as time wasted that should have been spent doing other things rather than just hanging around the clinics. Due to the lack of those services that directly involve men when they are at the ANC and PNC clinic, most men choose not to go there because they will spend time doing nothing as well as gaining nothing. In addition, men can be hindered to go to the clinic by the nature of activities that take place in those clinics; some reported witnessing embarrassing scenarios such as women delivering and such kind of things. The latter can negatively affect men's involvement in ANC and PNC especially when it comes to accompanying their partners to the clinic.

In any health setup, one of the roles of healthcare workers is to create demand for uptake of services through health education to the public. The lack of emphasis and proper education to men as far as their importance in ANC and PNC is concern is a major barrier to their involvement. Considering the fact that most men lack the knowledge on how their partners, children and themselves will benefit from their getting actively involved in ANC and PNC, there is a proportionately small number of men being actively involved. The lack of knowledge that is as a result of less health education therefore comes in as a barrier to their involvement in ANC and PNC.

The findings of this study also revealed that men were discouraged from accompanying their partners' to the clinic because the ANC and PNC clinics are spaces characterized by a dominant number of women and very few men. Since most men would not want to be the odd ones out while at the clinic, they either choose to stand far away from the buildings, go back home or never just come. Their absence at the clinic denies them a chance to get further informed about ANC and PNC especially through health talks at the clinic and the posters on the walls of the clinics. Also, the attitude of health care workers came out clear as one of the barriers to men's involvement in ANC and PNC. It was reported in the findings that some healthcare workers told men to stay back as they served their partners' whereas others talked to them disrespectfully. Such treatment by healthcare workers discourages men from going to the clinic hence lowering their involvement in ANC and PNC.

It is therefore important to note that health facility based factors are crucial in determining men's involvement in ANC and PNC. Most ANC and PNC services take place in the maternal and child health clinics and the only way to bring men on board is by creating a friendly environment

for them. In the event that the environment is not friendly for them, they will be discouraged from being actively involved and remain to be sponsors of women during and after pregnancy

### **8.3 Conclusion**

From the findings of the study, it is evident that men are involved in ANC and PNC though at different levels. This study was keen in understanding the cultural, economic and health facility-based factors that barred men from actively participating in ANC and PNC. It was clear that these factors play a fundamental role in determining to what extent these men will be involved in antenatal and postnatal care. It is conclusive enough that culture plays a role in influencing men's behaviour as far as their involvement in ANC and PNC is concerned and therefore acted as a barrier to some extent. However, due to the changes that have occurred over time courtesy of western socialization and the introduction of formal health systems, culture is no longer a significant barrier to men's involvement in antenatal and postnatal care.

On the other hand, economic barriers to men's involvement in ANC and PNC came out strongly. Considering the fact that men were thought to be the primary breadwinners in their families yet had low incomes and unstable occupations, they had to commit most of their time to work in order to provide food and other needs for their families. The latter means that they will have less time to actively participate in ANC and PNC.

Lastly, the most conspicuous barriers that came out were those related to health facilities. It should be noted that most ANC and PNC services either take place in a health facility or are directly linked to existing health systems. However, men's major barrier to their involvement in ANC and PNC is that there are notably few services that actively engage them especially at the clinic level. Most services offered directly target women and children and even to some extent that ANC and PNC clinics are referred by laymen as '*women's clinic*' and '*children's clinic*' respectively.

### **8.4 Recommendations**

On the basis of the above conclusions, the study makes the following recommendations:

1. Stakeholders in the maternal health sector should create awareness among men on those services that they could actively get involved in whenever they accompany their partners to the antenatal and postnatal clinics.

2. All healthcare workers should be sensitized on the need of accommodating men in antenatal and postnatal services and being non-judgmental while serving them since men are key shareholders in women's and children's health.
3. Clinics should organize for flexible operating days such as weekends to accommodate men who are barred from attending ANC and PNC on weekdays because of the nature of their work.

### **Recommendations on future research**

1. Future studies should consider exploring women's perceptions on barriers to their male partners' involvement in antenatal and postnatal care considering the fact that this study only captured perspectives from men and healthcare providers on barriers to male involvement in ANC and PNC.
2. A study of motivators to male involvement in antenatal and postnatal care will be useful since this study found out that some men had been involved in their partners ANC and PNC in one way or another and therefore it would be useful to understand what motivated their involvement.

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## **APPENDICES**

### **APPENDIX I: INFORMED CONSENT**

#### **CONSENT FORM FOR SURVEY PARTICIPANTS-ENGLISH**

#### **BARRIERS TO MEN'S ACTIVE INVOLVEMENT IN ANTENATAL AND POSTNATAL CARE IN BUTULA SUB-COUNTY, WESTERN KENYA**

Principal Investigator\and institutional affiliation:

Fernandos Kredgie Ongolly

Institute of Anthropology, Gender, & African Studies, University of Nairobi

Introduction:

I would like to tell you about a study being conducted by the above listed researchers. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be a participant in the study. Feel free to ask any questions about the purpose of the research, what happens if you participate in the study, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions to your satisfaction, you may decide to be in the study or not. This process is called 'informed consent'. Once you understand and agree to be in the study, I will request you to sign your name on this form. You should understand the general principles which apply to all participants in a medical research: i) Your decision to participate is entirely voluntary ii) You may withdraw from the study at any time without necessarily giving a reason for your withdrawal

iii) Refusal to participate in the research will not affect the services you are entitled to in this health facility or other facilities. We will give you a copy of this form for your records.

May I continue? YES / NO

#### **What is this study about?**

The researchers listed above are interviewing men who have had children in at least the past one year. The purpose of the interview is to find out the barriers to male involvement in antenatal and postnatal care. Participants in this research study will be asked questions about how they are involved in ANC/PNC as well as their frequency of involvement in maternal health services as well as barriers to their involvement in antenatal and post natal care. There will be approximately 96 participants in this study randomly chosen. We are asking for your consent to consider participating in this study.

#### **What will happen if you decide to be in this research study?**

If you agree to participate in this study, the following things will happen:

You will be interviewed by a trained interviewer in a private area where you feel comfortable. The interview will last approximately 10 minutes and your responses will be filled in a questionnaire. The audio will be transcribed and then analyzed after which it will be deleted from the computers.

**Are there any risks, harms discomforts associated with this study?**

There are no foreseeable risks or benefits to you for participating in this study. There is no cost or payment to you. If you have questions while taking part, please stop me and ask. I will do my best to keep your information confidential but we cannot guarantee absolute confidentiality because at one point I will have to share the information that I get from the field with my supervisor. We will link your answers to you initially by assigning special participant identity to the questionnaires/scripts but this link will be removed later in order to protect you.

**Are there any benefits being in this study?**

Participating in the study is voluntary and you may not get direct benefits from the study.

**Will being in this study cost you anything?**

Participating in the study is voluntary and it will not cost you anything apart from your time.

**Will you get refund for any money spent as part of this study?**

There is no reimbursement for your participation in the study

**What if you have questions in future?**

If you have further questions or concerns about participating in this study, please call or send a text message to the study staff at the number provided at the bottom of this page.

For more information about your rights as a research participant you may contact the Secretary/Chairperson, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee Telephone No. 2726300 Ext. 44102 email [uonknh\\_erc@uonbi.ac.ke](mailto:uonknh_erc@uonbi.ac.ke).

**What are your other choices?**

Your decision to participate in research is voluntary. You are free to decline participation in the study and you can withdraw from the study at any time without injustice or loss of any benefits.

**CONSENT FORM (STATEMENT OF CONSENT)**

**Participant's statement**



I have read this consent form or had the information read to me. I have had the chance to discuss this research study with a study counselor. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study.

I understand that all efforts will be made to keep information regarding my personal identity confidential.

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I agree to participate in this research study: Yes No

I agree to have (define specimen) preserved for later study: Yes No

I agree to provide contact information for follow-up: Yes No

Participant printed name: \_\_\_\_\_

Participant signature / Thumb stamp \_\_\_\_\_ Date \_\_\_\_\_

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has willingly and freely given his/her consent.

Researcher's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_

Role in the study: \_\_\_\_\_ [i.e. study staff who explained informed consent form.]

For more information contact Fernandos Kredgie Ongolly on 0705492838 or Dr. Salome Bukachi on 0726771808

Witness Printed Name (If witness is necessary, A witness is a person mutually acceptable to both the researcher and participant)

Name \_\_\_\_\_ Signature /Thumb stamp: \_\_\_\_\_

Contact information \_\_\_\_\_ Date; \_\_\_\_\_

## **CONSENT FORM FOR FGD PARTICIPANTS**

### **BARRIERS TO MEN'S ACTIVE INVOLVEMENT IN ANTENATAL AND POSTNATAL CARE IN BUTULA SUB-COUNTY, WESTERN KENYA**

Principal Investigator\and institutional affiliation:

Fernandos Kredgie Ongolly

Institute of Anthropology, Gender, & African Studies, University of Nairobi

Introduction:

I would like to tell you about a study being conducted by the above listed researchers. The purpose of this consent form is to give you the information you will need to help you decide whether or not to be a participant in the study. Feel free to ask any questions about the purpose of the research, what happens if you participate in the study, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions to your satisfaction, you may decide to be in the study or not. This process is called 'informed consent'. Once you understand and agree to be in the study, I will request you to sign your name on this form. You should understand the general principles which apply to all participants in a medical research: i) Your decision to participate is entirely voluntary ii) You may withdraw from the study at any time without necessarily giving a reason for your withdrawal

iii) Refusal to participate in the research will not affect the services you are entitled to in this health facility or other facilities. We will give you a copy of this form for your records.

May I continue? YES / NO

#### **What is this study about?**

The researchers listed above are interviewing men who have had children in at least the past one year. The purpose of the interview is to find out the barriers to male involvement in antenatal and postnatal care. Participants in this research study will be asked questions about how they are involved in ANC/PNC as well as their frequency of involvement in maternal health services. There will be approximately 96 participants in this study randomly chosen. We are asking for your consent to consider participating in this study.

#### **What will happen if you decide to be in this research study?**

If you agree to participate in this study, the following things will happen:

You will be requested to take part in a discussion with 11 other participants in a private area where you feel comfortable to participate. The discussion will last approximately 30 minutes

and you will be recorded using a digital audio recorder. The audio will be transcribed and then analyzed after which it will be deleted from the computers.

**Are there any risks, harms discomforts associated with this study?**

There are no foreseeable risks or benefits to you for participating in this study. There is no cost or payment to you. If you have questions while taking part, please stop me and ask. I will do my best to keep your information confidential but we cannot guarantee absolute confidentiality because at one point I will have to share the information that I get from the field with my supervisor. We will link your answers to you initially by assigning special participant identity to the questionnaires/scripts but this link will be removed later in order to protect you.

**Are there any benefits being in this study?**

Participating in the study is voluntary and you may not get direct benefits from the study.

Will being in this study cost you anything?

Participating in the study is voluntary and it will not cost you anything apart from your time.

**Will you get refund for any money spent as part of this study?**

There is no reimbursement for your participation in the study

**What if you have questions in future?**

If you have further questions or concerns about participating in this study, please call or send a text message to the study staff at the number provided at the bottom of this page.

For more information about your rights as a research participant you may contact the Secretary/Chairperson, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee Telephone No. 2726300 Ext. 44102 email uonknh\_erc@uonbi.ac.ke.

**What are your other choices?**

Your decision to participate in research is voluntary. You are free to decline participation in the study and you can withdraw from the study at any time without injustice or loss of any benefits.

**CONSENT FORM (STATEMENT OF CONSENT)**

**Participant's statement**

I have read this consent form or had the information read to me. I have had the chance to discuss this research study with a study counselor. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation

in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study.

I understand that all efforts will be made to keep information regarding my personal identity confidential.

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I agree to participate in this research study:	Yes	No
I agree to have (define specimen) preserved for later study:	Yes	No
I agree to provide contact information for follow-up:	Yes	No

Participant printed name: \_\_\_\_

Participant signature / Thumb stamp\_      Date \_\_

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has willingly and freely given his/her consent.

Researcher's Name: \_\_      Date: \_\_

Signature \_\_\_\_

Role in the study: \_\_\_\_ [i.e. study staff who explained informed consent form.]

For more information contact Fernandos Kredgie Ongolly on 0705492838 or Dr. Salome Bukachi on 0726771808

Witness Printed Name (*If witness is necessary, A witness is a person mutually acceptable to both the researcher and participant*)

Name\_ Signature /Thumb stamp: \_\_\_\_\_

Contact information \_\_ Date; \_

## APPENDIX II: QUESTIONNAIRE

PERSONAL INFORMATION			
101	Age	_____ Years	
102	Level of education	1. Primary 2. Secondary 3. University/College 4. Never attended school	
103	Occupation	1. Farmer 2. Employed casual 3. Employed formal 4. Self-employed/Own Business	
104	Number of children	_____ Children	
EXTENT OF INVOLVEMENT			
201	In your wife's last pregnancy how many times did she attend ANC/PNC?	<b>Antenatal clinic</b> 1. 1 visit 2. 2 to 4 visits 3. More than 5 visits 4. Don't know	<b>Postnatal Care</b> 1. 1 visit 2. 2 to 4 visits 3. More than 5 visits 4. Don't know
202	In your wife's last pregnancy how many times did you accompany her to the ANC clinic?	<b>Antenatal clinic</b> 1. once 2. 2 to 4 times 3. More than 5 times 4. Never	<b>Postnatal Care</b> 1. once 2. 2 to 4 times 3. More than 5 times 4. Never
203	How far from your home is the ANC/PNC clinic where your wife attended in her last pregnancy?	<b>Antenatal clinic</b> 1. 1 to 3km 2. 4 to 7km 3. More than 7km	<b>Postnatal Care</b> 1. 1 to 3km 2. 4 to 7km 3. More than 7km
204	What are the services offered at ANC/PNC that you know?	<b>Antenatal clinic</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	<b>Postnatal clinic</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
205	Do you think men's active involvement in ANC/PNC will be of any use to maternal health care?	<b>Antenatal clinic</b> 1. Yes 2. No	<b>Postnatal clinic</b> 1. Yes 2. No
<b>206 Answer the following questions appropriately</b>			
A	Did you accompany your spouse for ANC/PNC in her last pregnancy and after delivery?	<b>Antenatal care</b> 1. <b>Yes</b> 2. <b>No</b>	<b>Postnatal care</b> 1. <b>Yes</b> 2. <b>No</b>

<b>B</b>	Did you accompany your spouse for consultations/counseling during ANC/PNC visits	<b>Antenatal care</b> 1. <b>Yes</b> 2. <b>No</b>	<b>Postnatal Care</b> 1. <b>Yes</b> 2. <b>No</b>	
<b>C</b>	Did you join your spouse in group discussions during ANC/PNC	<b>Antenatal care</b> 1. <b>Yes</b> 2. <b>No</b>	<b>Postnatal care</b> 1. <b>Yes</b> 2. <b>No</b>	
<b>D</b>	I was with her at the health center during labor	<b>Antenatal care</b> 1. <b>Yes</b> 2. <b>No</b>	<b>Postnatal Care</b> 1. <b>Yes</b> 2. <b>No</b>	
<b>E</b>	Did you accompany your spouse for family planning advice during ANC/ PNC	<b>Antenatal care</b> 1. <b>Yes</b> 2. <b>No</b>	<b>Postnatal Care</b> 1. <b>Yes</b> 2. <b>No</b>	
<b>F</b>	Were you with your spouse during her delivery	<b>Antenatal care</b> 1. <b>Yes</b> 2. <b>No</b>		
<b>G</b>	Did you accompany her to take the child for immunization and check-ups?		<b>Postnatal Care</b> 1. <b>Yes</b> 2. <b>No</b>	
<b>207</b>	What care and support did you give to your wife during her ANC/PNC period? <b>(Multiple responses allowed)</b>	<b>Antenatal care</b> 1. Helped her with household chores. 2. Financial support. 3. Accompanied her to the clinic 4. Checked on her health physically	<b>Postnatal Care</b> 1. Helped her with household chores. 2. Financial support. 3. Accompanied her to the clinic 4. Checked on her health physically	
<b>208</b>	Where were you during the ANC/PNC session that you did not accompany your spouse to the clinic?	<b>Antenatal care</b> 1. At work 2. At home working 3. At home doing nothing 4. Had travelled	<b>Postnatal Care</b> 1. At work 2. At home working 3. At home doing nothing 4. Had travelled	
<b>209</b>	What services did you mostly get when you went to the clinic? <b>(Multiple responses allowed)</b>	<b>Antenatal care</b> 1. Counseling 2. Advices from doctor 3. Health education 4. None	<b>Postnatal Care</b> 1. Counseling 2. Advice from doctor 3. Health education 4. None	
<b>210</b>	In your culture, what roles do men play in their women's pregnancy?(Tick appropriately)		<b>Antenatal care</b>	<b>Postnatal Care</b>
		Accompanying them to clinics		
		Joining in health discussions at the clinic		
		Financing their health		
	Physically checking their wives/babies			

		Helping with household chores		
<b>BARRIERS (Multiple responses allowed)</b>				
<b>301</b>	According to you, how many times should a woman attend ANC/PNC?	<b>Antenatal clinic</b> 1. 1 visit 2. 2 to 4 visits 3. More than 5 visits 4. Don't know	<b>Postnatal Care</b> 1. 1 visit 2. 2 to 4 visits 3. More than 5 visits 4. Don't know	
<b>302</b>	At what point should men be involved in ANC/PNC?	<b>Antenatal care</b> 1. All the time 2. During emergencies 3. Should never be involved 4. Don't know	<b>Postnatal Care</b> 1. All the time 2. During emergencies 3. Should never be involved 4. Don't know	
<b>303</b>	Does your culture approve men accompanying their wives to ANC & PNC?	<b>Antenatal clinic</b> 1. Yes 2. No	<b>Postnatal Care</b> 1. Yes 2. No	
<b>304</b>	What are the social and cultural barriers that could hinder you from actively participating in ANC/PNC? (b	<b>Antenatal care</b> 1. Being mocked by other men 2. Being mocked by family members 3. Beliefs that maternal health is a woman's domain. 4. Influence from parents 5. Others (Specify)	<b>Postnatal Care</b> 1. Being mocked by other men 2. Being mocked by family members 3. Beliefs that maternal health is a woman's domain. 4. Influence from parents 5. Others (Specify)	
<b>305</b>	Do you consider yourself to be well informed about your involvement in ANC/PNC?	1. Yes 2. No	1. Yes 2. No	
	Do you consider yourself to have enough information about ANC/PNC	1. Yes 2. No	1. Yes 2. No	
	Where did you get the information that you have about ANC/PNC? ( <b>Multiple responses allowed</b> )	1. At the ANC clinic 2. From a community health worker 3. From a neighbor 4. From my spouse	1. At the PNC clinic 2. From a community health worker 3. From a neighbor 4. From my spouse	
<b>306</b>	Due to the lack of enough money have you ever been unable to actively participate in ANC/PNC	1. Yes 2. No	1. Yes 2. No	
	Are there those times when your work made it possible for you to actively participate in ANC/PNC	1. Yes 2. No	1. Yes 2. No	

	Do the costs of some services at the ANC/PNC clinic discourage you from being actively involved in ANC/PNC?	1. Yes 2. No	1. Yes 2. No
307	What would you say about the attitude of health care providers (staff) to men who accompany their wives for ANC/PNC?	..... ..... ..... .....	
308	What do you think are the factors in the antenatal clinic/Postnatal clinic that would make men not to actively participate in ANC/PNC? <b>(Multiple responses allowed)</b>	<b>Antenatal care</b> 1. Set up of the clinic 2. Activities at the clinic 3. Services offered 4. Attitude of the service providers 5. Profile of the clients 6. Expenses 7. Time taken	<b>Postnatal Care</b> 1. Set up of the clinic 2. Activities at the clinic 3. Services offered 4. Attitude of the service providers 5. Profile of the clients 6. Expenses 7. Time taken
309	Does your employer/employment support your clinic attendance by giving you Permission when necessary? Explain briefly.	1. Yes 2. No <b>(If Yes, write here: Ask for those who are employed)</b>	
<b>BENEFITS &amp; RECOMMENDATIONS(Multiple responses allowed)</b>			
401	What do you think is the importance of Accompanying your partner to the ANC?	<b>Antenatal care</b> 1. Will learn about the spouses health 2. Will improve maternal health 3. Will improve women's adherence to ANC/PNC 4. None	<b>Postnatal Care</b> 1. Will learn about the spouses health 2. Will improve maternal health 3. Will improve women's adherence to ANC/PNC 4. None
402	What strategies can we use to encourage other men to accompany their wives/partners to the clinic without feeling coerced?	<b>Antenatal care</b> 1. Through health education 2. Give incentives to men 3. Provide services that include men 4. Change of attitude by service providers 5. Make it mandatory	<b>Postnatal Care</b> 1. Through health education 2. Give incentives to men 3. Provide services that include men 4. Change of attitude by service providers 5. Make it mandatory



### **APPENDIX III: FOCUS GROUP DISCUSSIONS GUIDE**

1. Men's role during their wives' pregnancy and delivery (Probe: Men's ideal roles vis a vis their current roles).
2. Men's role at the clinic for ANC and PNC (Probe: What men do when they go to the clinic, how they help and how they participate to benefit their wives' health).
3. Services offered at ANC/PNC (Probe: Participant's knowledge of services offers at ANC/PNC clinic. Ask on those services that target both men and women).
4. Factors hindering men's involvement in ANC and PNC. (Give them freedom to mention their barriers).
5. Antenatal clinic setting/environment as a barrier to men's participation in ANC/PNC. Probe For: (**Services offered, profile of clients, the way the building is, service providers**)
6. Attitudes of health care providers as barriers to men's involvement in their wives for ANC/PNC.
7. Economic factors that hinder men's active involvement to ANC and PNC.
8. How men's active involvement will enhance maternal health care.
9. Strategies that can be put in place to encourage men's active involvement in ANC and PNC.

#### **APPENDIX IV: KEY INFORMANT INTERVIEW GUIDE**

1. Briefly describe how men participate in ANC and PNC in this location. Probe: Provision of transport, accompanying women to clinics, advice etc.
2. From your experience, describe what has been the role of men when they accompany their wives to ANC/PNC clinics? Probe: (Activities that they take part, where they sit and how they assist).
3. Describe any ANC/PNC services at this health center that specifically target men.
4. What ANC and PNC services offered at this health center actively involve both men and women?
5. What is your opinion on actively involving men in ANC and PNC?
6. What would you do if a man wanted to be in the ANC/PNC room with her wife during her wife's visit?
7. What are some of the challenges that men face when they accompany their wives for ANC/PNC?
8. Describe some of the barriers that could limit men's involvement in ANC and PNC in this community? In your opinion what benefits would involving men actively in ANC/PNC have to maternal health in this area?
9. What do you recommend as strategies of actively involving men in ANC/PNC?


## APPENDIX V RESEARCH BUDGET

Item	Amount	Quantity	Total
Transport	7000	NRB-BSA BSA-NRB Local travel	7000
Research assistant	2000 per day (4 days)	2	16000
FGDs Participants' compensation	250 per participant	16 Participants	24000
Guide	1000 per day 4 days	2 Guides	8000
Transcription & Translation	1500	8 FGDs 8 KII	24000
Printing and binding	5000	-	5000
Data Entry	50 per questionnaire	80 questionnaires	4000
<b>TOTAL</b>			<b>88,000</b>

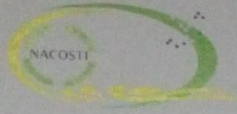
**APPENDIX VI: NACOSTI RESEARCH PERMIT**

**THIS IS TO CERTIFY THAT:** Permit No : **NACOSTI/P/17/31929/18899**  
**MR. FERNANDOS KREDGIE ONGOLLY** Date Of Issue : **7th September,2017**  
of **UNIVERSITY OF NAIROBI, 1928-100** Fee Recieved : **Ksh 1000**  
**NAIROBI, has been permitted to conduct**  
**research in Busia County**  
**on the topic: BARRIERS TO MENS**  
**INVOLVEMENT IN ANTENATAL AND**  
**POSTNATAL CARE IN BUTULA SUB**  
**COUNTY WESTERN KENYA**  
**for the period ending:**  
**5th September,2018**

*Jack Kredgie*  
.....  
**Applicant's Signature**

  
*J. Palem*  
.....  
**Director General**  
**National Commission for Science,**  
**Technology & Innovation**

## APPENDIX VII: NACOSTI RESEARCH AUTHORIZATION



### NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,  
2241349, 3310571, 2219420  
Fax: +254-20-318245, 318249  
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When replying please quote

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

Ref. No. **NACOSTI/P/17/31929/18899**

Date **7<sup>th</sup> September, 2017**

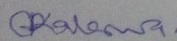
Fernandos Kredgie Ongolly  
University of Nairobi  
P.O. Box 30197-00100  
**NAIROBI.**

#### RE: RESEARCH AUTHORIZATION

following your application for authority to carry out research on "*Barriers to men's involvement in antenatal and postnatal care in Butula Sub County Western Kenya*" I am pleased to inform you that you have been authorized to undertake research in **Busia County** for the period ending **5<sup>th</sup> September, 2018**.

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

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

  
**GODFREY P. KALERWA MSc., MBA, MKIM**  
**FOR: DIRECTOR-GENERAL/CEO**

Copy to:

The County Commissioner  
Busia County.

The County Director of Education  
Busia County.

## APPENDIX VIII: KNH-UoN ERC APPROVAL LETTER



UNIVERSITY OF NAIROBI  
COLLEGE OF HEALTH SCIENCES  
P O BOX 19676 Code 00202  
Telegrams: varsity  
Tel:(254-020) 2726300 Ext 44355



KNH-UON ERC  
Email: [uonknh\\_erc@uonbi.ac.ke](mailto:uonknh_erc@uonbi.ac.ke)  
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Facebook: <https://www.facebook.com/uonknh.erc>  
Twitter: @UONKNH\_ERC [https://twitter.com/UONKNH\\_ERC](https://twitter.com/UONKNH_ERC)



KENYATTA NATIONAL HOSPITAL  
P O BOX 20723 Code 00202  
Tel: 726300-9  
Fax: 725272  
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/43

29<sup>th</sup> January 2018

Fernandos Kredgie Ongolly  
Reg. No.N50/82385/2015  
Institute of Anthropology, Gender and African Studies  
University of Nairobi

Dear Fernandos

RESEARCH PROPOSAL: "A STUDY OF MEN'S INVOLVEMENT IN ANTENATAL AND POSTNATAL CARE IN BUTULA SUB-COUNTY, WESTERN KENYA (P392/07/2017)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH- UoN ERC) has reviewed and **approved** your above revised proposal. The approval period is from 29<sup>th</sup> January 2018 – 28<sup>th</sup> January 2019.

This approval is subject to compliance with the following requirements:

- a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
- b) All changes (amendments, deviations, violations etc) are submitted for review and approval by KNH-UoN ERC before implementation.
- c) Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
- d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
- e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
- f) Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment
- g) Submission of an *executive summary* report within 90 days upon completion of the study.  
This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

For more details consult the KNH- UoN ERC website <http://www.erc.uonbi.ac.ke>