An Exploration of The Role Played by Men During Pregnancy and Childbirth in Kenya: A Case of Kitui West Sub County

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Abstract

According to gender mainstreaming principles, male involvement during pregnancy and childbirth is a pivotal strategy for improving birth outcomes. The objective of this study was to gain a deeper understanding of the role played by husbands and fiancées during pregnancy and childbirth. To gather data, 135 Antenatal care (ANC) attendees, 30 non-ANC-attendees, 5 nurses and 8 TBAs were interviewed from 10 randomly selected health facilities from 18 health facilities that offer comprehensive health care. This information was collected between 2017 and 2018 in Kitui West- Sub-County, Kenya and was collected through asking two pertinent questions; a) Whether expectant women sought permission before choosing place of delivery, b) Who determined final place of delivery. The study utilized quantitative and qualitative methods of study. Analysis of the study was done by content. From the results; 50 percent of 64 ANC-attendees, sought permission from their husbands where to deliver while 33.3 percent of 9 non-ANC-attendees sought permission from husbands where to deliver as well. Final place of delivery indicated that; 64 percent out of 135 ANC-attendees delivered in a health facility, 34 percent out of this number were encouraged by significant others. Fifty six percent out of the significant ones were husbands who directed their wives to deliver in a health facility. Out of 49 ANC-attendees who delivered at home, 36.7 percent were influenced by significant others. Out of these significant others, 27 percent were husbands. On the other hand, 6 respondents out of 30 non- *ANC-attendees, delivered at home having been instructed by their husbands.*

Key words: ANC-attendees, non-ANC-attendees, husbands, fiancées, significant others

1.0 Introduction

The role played by husbands during pregnancy and childbirth has shown a positive outcome of pregnancy. On the other hand, it ensures men's involvement in their future role as fathers (Kaye et al.; 2009). Husbands' role during pregnancy cannot be ignored since they are expected to seek medical help in case of complications, organize for transport and allocate household resources (Lewis et al.;2015). An international conference held in Egypt, Cairo in 1994 which focused on Population and Development agreed that, good reproductive health was a right to women and men alike. Therefore, together men and

women should make decisions regarding issues of reproduction (Dudgeon &Inhorn, 2004). In this conference, the participants were in agreement that, unless men and women discuss issues of reproductive health, they were unable to enjoy sexual relationships. It was also observed that, men were key players in influencing reproductive health outcomes of their wives and children positively or negatively, indirectly or directly (Dudgeon &Inhorn, 2004).

Carter (2002) emphasizes that, male relationships in matters pertaining to reproductive health can bring positive health benefits for women who would view this as a social support. Carter further observes that male involvement could influence pregnant women to utilize various reproductive health services such as attendance of ANC, checks ups in case of illness and health facility delivery. In support of what Carter points out in the above assertions, Bhalerao et al. (1984) maintain that husbands' involvement in women's reproductive health increased their frequency in counseling during antenatal visits and significantly lowered maternal and infant mortality rates. Varkey et al. (2004) concede that men involvement during antenatal consultations increases couples' dialogue and utilization of contraception and a better understanding of pregnancy and childbirth.

A research carried out by Mullany, Becker and Hindin (2007) in Kathmandu Nepal indicated that, educating husbands and their wives yielded a greater impact on maternal health care in comparison with educating the pregnant women alone. Interestingly, Alio et al. (2010) who carried out a study of feto-infant health in Gorkha district, in Western region of Nepal, acknowledged that paternal behaviours in the maternal period could have long-lasting effects on the child's health. Kaye et al. (2014) make this point clearer by contending that, male involvement during pregnancy reduces maternal stress by providing emotional, financial as well as logistical support. This support in turn reduces risk of premature labour, low birth weight and increases ANC attendance and ensures men's involvement in their future parental roles from an early stage.

A research carried out by Kahsay and Gebrehiwot (2012) on Assessment of Husbands' Readiness, and Participation during childbirth in Enderta Woreda, Tigray Region, Ethiopia showed that, preparing for a birth of a baby is an important strategy because it is part of safe motherhood. This preparation according to the above authors may be affected by the participation of the male partners because they are the most influential decision makers in terms of family matters. Therefore, this preparation makes husbands essential partners for the welfare of mother and child which reduces maternal mortality rate. As evidence, this study by Kahsay and Gebrehiwot (2012) showed that, 15.5 percent of pregnant women did not attend ANC because their husbands disapproved it andonly 21 percent of the husbands accompanied their wives to the ANC. Contributing to the low percentage of husbands' involvement in childbirth, Kahsay and Gebrehiwot (2012) intimate that; "*many men in low resource countries do not accompany their partners to the health facility during pregnancy unless there is a complication. Others wait outside at the clinic while the woman participates in health talk and consultation with the health worker".*

These views are further supported by Sarah Lewis, Andrew Lee and Padam Simkhada(2015) who lament that, the role of husbands in maternal health is often overlooked and neglected. These researchers maintain that in South Asian contexts, men possess little knowledge and experience regarding maternal health hence

limiting their involvement in maternal health. This lack of knowledge undoubtedly affects maternal health outcomes. For example, Brunson's (2010) study shows that despite the fact that men may not be knowledgeable about birth, in emergencies men control the situation through their decision making.
Given the preceding discussion, the aim of this study was to examine the involvement of men during pregnancy and childbirth in a rural setting like Kitui west sub-County with a view of understanding factors that embed their involvement.

1.1 Research objectives

1. To explore if women collaborated with their husbands/fiancées before deciding place of birth
2. To establish who decided final place of delivery
3. To contribute to policy on male involvement in the place of delivery of infants.

2.0 The study site was Kitui West Sub County which is one of the 16 sub counties Kitui County. According to 2009 census, the population of women at child bearing age (15 – 49 years) was 1,230 in Kitui West Subcounty (KNBS et al.; 2009). Health facilities were 261 with 3 County hospitals and 8 sub-county hospitals at the time of this research. According to the District Public Health Nurse in charge of the health facilities in Kitui West Sub County, there were 22 health facilities. Out of these facilities, 18 offered integrated maternal health care services.

3.0 Research methodology

The research was carried out in 10 randomly selected health facilities out of 18 in Kitui West sub County. The study employed both qualitative and quantitative methods and focused on 135 ANC-attendees and 30 non attendees. According to 2009 census, the population of women at child bearing age (15 – 49 years) in Kitui west sub-county was 1,230 (KNBS et al.; 2009). To calculate the sample size for pregnant women within the 10 health facilities, the following formula was used; 1,230 x 15/100=184.5 rounded up to 185. From each facility the researchers intended to interview 19 pregnant women which was arrived at by dividing 185/10 = 18.5, rounded up = 19 pregnant women. However, some of the health facilities had less numbers and in the final end, a total of 165 pregnant women were interviewed.

Written consent were obtained from the Cabinet Secretary, Ministry of Health, Kitui County while verbal consent were obtained from the Public Health Nurse in charge of Kitui West sub County health facilities. The researchers ensured that the respondents gave verbal consent as well before engaging them in the data collection exercise. The instrument for data collection in this study was an In-depth Individual Interview Guide. The data collection instrument was pre-tested in various health facilities to ascertain validity and reliability of the instrument. Two research assistants were recruited and trained and used in data collection. The raw data was organized into a format that could easily be analyzed and make presentation feasible. The data was then transcribed to make a meaning while emerging themes and patterns were identified, coded and categorized. The Statistical Package of Social Sciences (SPSS) version 21, was used for analyzing the quantitative data. Descriptive characteristics of respondents were analyzed including

crosstabulations.to test associations of the variables.Significance level for statistical analysis was set at 95% (P≤0.05) confidence level. The key questions in the interview guide included:

3.1 Interview Guide for the Pregnant women

Section I: Personal Details of the Pregnant Woman

Name of Facility…….....
Interview date…….....
Respondent number…….....
Name of respondent…….....
Contact of respondent …….....
Village …….....

In the responses, pseudonyms were given to the respondents to conceal their identity

Section II: Before delivery

1. Where are you planning to deliver the baby? Explain
2. Do you need to seek permission before you choose place of birth? Explain

Section II: After delivery

1. Who finally decided place of birth?

3.1.1. Results.

Out of the total --- women who were reached by the study and were attending ANC, the resulted showed that 93 percent intended to deliver in a health facility while 2 percent of these respondents intended to deliver at home. On the other hand, out of the 30 non-ANC-attendees, 60 percent had indicated that they intended to deliver their babies at home. But at the time of delivery, interesting things took place. The 93 percent of ANC-attendees who envisioned delivering in a health facility reduced by 29 percent to stand at 64 percent. The 2 percent of ANC-attendees who planned to deliver at home drastically increased by 34 percent to 36 percent. Interestingly, the 60 percent of non-ANC-attendees who categorically said they would deliver at home, increased by 30 percent 90 percent.

What would have brought such divergence in the original plans of these respondents? This study revealed that the role played by husbands, fathers of unmarried respondents and fiancees in determing final place of delivery was significant. For instance, 64 percent of the 135 ANC-attendees who delivered in a health facility, 34 percent noted that they were encouraged by their significant others to deliver in a health facility. Out of the 34 percent of respondents referred, 56 percent of them were encouraged by husbands, 7 percent of unmarried respondents by their fathers and 3 percent by fiancées. Out of 49 ANC-attendees who delivered at home, 36.7 percent delivered at home having been influenced by significant others. Twenty seven percent of these significant others included husbands, 6 percent were fathers of unmarried respondents and another 6 percent by fiancées.

According to this study, husbands seemed to have had the greatest influence over where the baby would be born. In some instances, they simply dictated where the delivery would take place. One respondent had this to say about the husband's influence to deliver at home: *"I delivered safely at home because I was encouraged by my husband to deliver there. In fact, I had intended to give birth in a health facility though I had not specified a particular one".* Two other respondents maintained that their husbands were the custodians of the family resources and had the mandate to decide where the baby would be delivered. On the same note, these women further claimed that since their husbands were the heads of the family according to Akamba culture, they had absolute right to identify place of birth for the baby.

On a different situation, one of the respondents said that she was surprised when her husband insisted that she had to give birth at home. To expound on her experience she further said, *"Although I had planned to deliver my baby in a health facility, when my husband realized that I was in labour, he called a TBA instead of organizing for transport to a health facility. Nevertheless, the TBA conducted the delivery safely at home"*. The domination by husbands regarding decisions for place of delivery was exemplified by Syomiti who said, *"My husband and my mother-in-law encouraged me to give birth at home and I complied because I did not want to cause a conflict in the family".*

The place of delivering the baby for other 6 respondents; Syokwia, Mwiia, Mwiitu, Wakyende, Wendo and Musau was determined by their husbands. Syokwia had previously delivered 2 children safely, one in a health facility and the other at home. Mwiia and Mwiitu had previously delivered 4 children each at home without any childbirth complications. *"My husband told me to deliver the current baby at home. When he noticed that I was in labour he called a TBA and I delivered a baby girl",* said Mwiia. Just as Mwiia, Mwiitu delivered at home assisted by a TBA and her mother-in-law as planned by her husband. Wakyende, Wendo and Musau all delivered at home assisted by TBAs as proposed by their husbands. These 4 respondents delivered 3 girls and one boy, respectively. Wakyende, Wendo and Musau safely delivered 3 of their children at home. They maintained that, their husbands were the head of their families and therefore they were responsible for determining where the baby would be delivered. Besides, they provided financial support in emergency cases.

A father of one of the unmarried respondents encouraged her to deliver her baby at home. She claimed that her father encouraged her to deliver at home because of the care and concern by relatives. When labour pains began, a TBA was called and she delivered a baby boy safely at home. Mukeli aged 19, and expecting her first baby, delivered a baby boy at home because of her father's influence. One other respondent had a different experience during childbirth at home. Her experience was captured in the extract below:

> *My fiancée had promised to support me to give birth in a health facility but he was not available at the time when labour began. I was so disappointment because my family members were not prepared pecuniary wise for a delivery in a health facility. I did not have money to facilitate my movement from home to the health facility. The only option was to call a TBA who conducted the delivery. I delivered a baby boy without any challenge.*

For the 30 non-ANC-attendees, 37 percent of the 27 respondents who delivered at home were encouraged by significant others. Husbands accounted for 26 percent while fathers were 4 percent. A respondent aged 19, and expecting her first baby, delivered a baby boy at home because of her father's influence. Like the

ANC-attendees, the 26 percent non-ANC-attendees who delivered at home claimed that their husbands played a key role in choosing where to deliver.

4.0 Discussion

The significance role played by husbands and fiancees is a profound issue in the process of childbirth for both young and aged pregnant women. Its critical to note that anything can happen when delivering at home and any loss of life even of one life which could have been safed is critical. This study revealed that young pregnant women between 17 and 22 years, 12 percent relied on their husbands to choose a place of delivery. Interestingly, a similar trend of relying on husbands to choose a place of delivery was also observed in the age bracket from 26 to 34 years where 93 percent of them were married and 34 percent of them depended on their husbands regarding where they would deliver their babies. The 25 ANC-attendees, who delivered some of their children in a health facility and others at home, 26.7 percent were encouraged by their husbands to deliver in a health facility.

Spousal union according to Levinson (1978) is unique relation which requires proper mentorship. This explains why – out of 135 respondents who were ANC-attendees who had previously given birth, 32 percent sought permission from their husbands while 33.3 percent of the 30 non-ANC-attendees relied on their husbands to choose for them place of delivery. Two percent of the ANC-attendees were ambivalent where to deliver and were waiting for their husbands to decide for them.

This study also established that before the pregnant women could decide where to deliver, quite a significant number had to seek prior permission speciffically from their husbands. For instance, 47 percent out of the 135 ANC-attendees and 30 percent of the 30 non-ANC-attendees sought permission from significant others before deciding where to deliver their babies. As already mentioned, out of the 64 ANC-attendees, 50 percent of them sought permission from their husbands while 33 percent out the 9 non-ANC-attendees sought permission from their husbands as well. To confirm this dominant role by husbands over their wives, Leone (2016) conducted a research in Sunamganj, Bangladesh in 2015 and established that husbands made 50 percent of the decisions at family level regarding maternal and healthcare utilization. Magoma et al. (2010) in their research came up with similar views regarding influence of husbands on choice of place of delivery for their wives. Their research which was conducted in Ngorongoro, Arusha, Northern Tanzania in 2008, revealed that husbands usually made sure that they chose place of delivery for their wives among the Maasai and Watemi communities.

This in control of pregnant women by husbands may stems from lack of less automy of among the pregnant women. Woldemicael (2007) views women's autonomy in decision making as pivotal in choosing the use of maternal and child health care services. On the other hand, Magoma et al., (2010) found out that women who lacked autonomy in choosing place of delivery experienced challenges in accessing maternal health care services because their decisions were perpetually interfered with by others. It is interesting to note that even the pregnant women who claimed to be autonomous in choosing place of delivery, their decisions had to be ratified by their husbands. The TBAs interviewed tried to show some light on this issue

about the decision of where to deliver. Sixty three percent out of the 8 TBAs interviewed firmly affirmed that a woman could not possibly go against her husband's wish. For instance, Ng'amuli maintained that a married woman could not go against her husband's decision. To elaborate this further, she narrated using a story:

> *A certain pregnant woman planned to deliver in a health facility but the husband refused to let her do so. She packed a few of her belongings and came to ask me to accompany her to the health facility. Since I did not want to cause a conflict in her family, I urged her to comply with her husband's directives. However, I prepared her on how to await for the baby by having a new razor blade, clean cord ligatures for tying the baby's cord, a* clean *mattress and a clean bed sheet. I advised her to ensure that the baby's cord was tied 3 times and demonstrated to her how to separate the cord from the placenta. I also demonstrated to her how to deliver the placenta and how to examine it to ensure that there were none retained pieces of the placenta in the uterus.*

All the TBAs unanimously stressed that, the husband had the final say regarding where the baby would be delivered. If the woman wanted to deliver in a health facility, probably she could persuade her husband to accept her point of view. They conceded that a woman cannot deliver in a health facility without her husband's consent. She could only do so if the situation warranted referral to a health facility. From the above narrations, the TBAs raised key tradition issue where a married woman could not contravene her husband's wish. The TBAs were asked; **what happens in the event that the pregnant woman cannot deliver at home?** In answer to the above question, two of the TBAs said that they would inform the mother-in-law who was expected to contact the husband of the woman in labour to organize for transport or come to a consensus on what to do. Or else, the problem would be brought direct to the attention of the husband because he had the final say about what was to be done next. Such clearly shows some of the delays which at times may cause the life of the woman, child or both. One of the TBAs summarized this issue of husband's control over the wife by contending that; *"In matters related to pregnancy and childbirth and according to Akamba culture, it is the prerogative of the husband because he knows how many children he wants to have and where they should be delivered'*. The views of these respondents are supported by Owino and Legault (2013) who point out that place of delivering the baby for married women was chosen by their husbands.

One of the nurses interviewed noted that:

> *Some pregnant women will seek advice from their husbands regarding place of delivering the baby and stick to the guidance given irrespective of the consequences. Some other pregnant women will go to an extent of waiting for their husbands to sign for them the medical operation form if they were required to undergo caesarean section. Majority of the pregnant women were aware of their reproductive rights. Staff from our health facilities try to take some time to educate the pregnant women on these rights but without much success. The decisions of pregnant women, who were not aware of these rights, were to a large extent influenced by their husbands, parents and mothers-in-law.*

5.0 Conclusion

Significant others especially husbands played an important role in encouraging respondents to deliver in a health facility or at home. The underlying factor in husbands' control in matters of reproductive health was that, according to Akamba culture, they were the breadwinners, the head of family households and providers of financial support in emergency cases.

Recommendations

This study has recognized some challenges that extend to cultural beliefs and practice. For instance, the cultural belief that men are sole designers of a family set up. In fact, the TBA could be facilitated by the MoH to be a link between some of these limiting cultural practices and influence pregnant women to prefer health seeking behavior. Based on the number of women who were encouraged by significant others especially the husbands to deliver at home, the study recommends a male research study to find out if the knowledge of the husbands regarding possible complications that could occur during childbirth was deep enough to encourage women to choose to deliver in a health facility. It's important to establish whether beyond the money issue whether men were concerned about consequences or they were just fatalistic.

The findings also raised important concerns of why husbands and significant others in the environment of a pregnant woman especially in the rural areas need more awareness on the importance of delivering in the health facilities. Its critical to continue to inform the society on the matters of why a live whether of a mother or child should not be lost due to health reasons which are completely preventable.

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