

Pregnancy and childbirth: male partner involvement in Uasin Gishu, Kenya

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Abstract

Introduction In many African countries, pregnancy and childbirth has traditionally been regarded as a woman's affair. As a result, male partner involvement and participation in pregnancy and childbirth has been minimal, which is thought to have contributed to the high rate of maternal and neonatal morbidities and mortalities. Male partners are often key decision-makers in African households for cultural reasons, yet their role in pregnancy and childbirth is not clearly defined. The aim of this study was to examine and document male partner involvement in maternal healthcare in Kenya.

Methods A health facility-based cross-sectional descriptive study design was used. Systematic random sampling was used to select 384 women seeking maternal and child healthcare at Uasin Gishu County Hospital. The participants were interviewed using structured interviewer-administered questionnaires.

Results Almost a third of participants (32%) reported never being accompanied by their partners to maternity clinic visits, while 41% were accompanied only for HIV counselling and testing. Over half of respondents reported that their partners provided a fare or transport to the antenatal clinic (55%) and that they were supported when taking iron and folic acid supplements (58%). Just over a third of participants reported their partners took them to the hospital during labour (37%). Only 8% of male partners were present during labour and birth, 55% provided money to travel home after the birth and less than a fifth (19%) accompanied their wives home after birth.

Conclusions Male partner involvement in maternal care is very low in Uasin Gishu county. Male partner involvement needs to be recognised and addressed in health education because of the potential benefits to both maternal and child health outcomes. Health systems should focus on providing couple-friendly antenatal care services. Maternal health intervention strategies and policies that inadvertently isolate men from active engagement in antenatal and postnatal health programmes should be reviewed.

Key words: Antenatal care; Iron and folic acid supplementation; Labour and childbirth; Male partner; Maternal care; Maternal health; Social support

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Introduction

Male partner involvement in antenatal care and birth is an important element of safe pregnancy and birth. Approximately 210 million women worldwide become pregnant every year, and 15% of these women experience maternal complications that, if left untreated, may cause harm to the mother or baby (Bakhri, 2015). An estimated 303 000 maternal deaths are recorded globally every year (World Health Organization, 2019). The majority of these deaths are the result of complications associated with pregnancy, labour or childbirth (World Health Organization, 2019).

An important risk factor that affects maternal wellbeing is a lack of male partner involvement in pregnancy and childbirth. Studies have shown that interventions aimed at including men in maternal health issues improve maternal and child health outcomes (Yargawa and Leonardi-Bee, 2015; Tokhi et al, 2018; Kriel et al, 2019). These studies have linked men's involvement in maternal health to positive benefits, including an increased likelihood of contraceptive use (Kriel et al, 2019), antenatal care attendance, skilled birth attendants, facility birth, postpartum care attendance, birth complications

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preparedness and maternal nutrition (Tokhi et al, 2018). The World Health Organization (2015) recommendations for maternal and newborn health advise that men should be actively involved during pregnancy, childbirth and the postpartum period.

However, male partner involvement in pregnancy and childbirth, especially in low-and middle-income countries where women may not have access to economic resources or the power to make household decisions, remains minimal (Afulani et al, 2018; Mersha, 2018; Muheirwe and Nuhu, 2019). This is mainly because in most African settings, pregnancy and childbirth, and by extension childrearing, have traditionally been viewed as women's affairs (Serpell, 1992). Pregnant women are most commonly given support during labour and childbirth by female relatives, such as their mother-in-law or sisters (Erzse et al, 2021). Little is known about the extent or precise nature of the social support provided by male partners in the African context during pregnancy, childbirth and the postnatal period.

Global studies investigating male relatives and maternal and child healthcare have mainly explored barriers and opportunities for men's involvement (Exner et al, 2009; Davis et al, 2013; Lowe, 2017; Morgan et al, 2017; Sharma et al, 2018; Tokhi et al, 2018; Kabanga et al, 2019; Ongolly and Bukachi, 2019; Gibore and Bali, 2020). These studies established that most men are aware of the benefits of being involved in maternal health, but factors such as the perception of pregnancy support as a female role (Afulani et al, 2018), negative attitudes from health workers toward men's involvement and unwelcoming antenatal care services have limited men's involvement (Gibore and Bali, 2020). Some studies have reported that gender norms and expectations hinder men's involvement in reproductive healthcare and their access to programmes and services (Lowe, 2017; Afulani et al, 2018; Muheirwe and Nuhu, 2019). A study from a health facility in Bangladesh noted that the number of women who came to the facility for birth was small; this was because the majority of male partners reportedly believed that pregnancy and childbirth was a natural physiological process and not a sickness that mandated a visit to the hospital (Story et al, 2012). Women who sought services at health facilities for pregnancy and birth were compelled by informed family members (Story et al, 2012).

In most African countries, men are often in control of household resources and are responsible for making significant decisions in the family, including those that might influence maternal health and pregnancy outcomes (Aborigo et al, 2018). Therefore, it is important to understand men's role in maternal health care. This facility-based study was designed to investigate the extent of male partner involvement in antenatal care, labour and birth in Uasin Gishu, Kenya.

Methods

This study used a cross-sectional, descriptive, health facility-based survey design. The participants were women seeking maternal and child healthcare at Uasin Gishu County Hospital in Eldoret, Kenya between June and August 2016. This hospital was selected for the study because of the availability of free maternity care services including quality antenatal care, clean and safe birth facilities and postpartum care, as well as its accessibility for the 12 653 women of reproductive age living in both rural and urban areas of Uasin Gishu (Department of Health Services, 2018). The hospital provides antenatal services to an average of 1000 women each year, with approximately 70 births per month and 30 women seeking follow-up postnatal care each month (Department of Health Services, 2018).

The sample size for the study was calculated using Fisher's formula (Jung, 2014), taking 5% as the desired precision level, a 95% confidence interval and 50% as an estimate of the proportion of male partner involvement in pregnancy, yielding a sample size of 384 women (Gray, 2004).

Systematic random sampling was used to select study participants. The first participant was selected arbitrarily and subsequently, every third participant was included, based on hospital medical records of expected attendance at the maternal child health clinic over a 3-month period, taking into account the calculated sample size. The sampling frame was all resident married or unmarried women aged 18 years or older attending maternal and child health services at the Uasin Gishu County Hospital who were willing and able to participate.

Data collection

Researcher-administered questionnaires were used to collect data from the participants. Data collection was coordinated by the third author (LM) and conducted by a team of the authors (JM, PMJ, SK, PCT, CS, TK) who were fluent in local dialects, English and Swahili, and had nursing and public health research experience. The questionnaire was developed in English by the first author, then reviewed and refined by the rest of the study team and translated to Swahili, then back-translated by an expert linguist to ensure consistency and clarity.

Before data collection, the questionnaire was pre-tested with 39 participants at the Moi Teaching and Referral Hospital, a health facility that was not included in data collection. To ensure the questionnaire's reliability, a test retest (Cohen's kappa statistic) was conducted and a repeat pre-test was conducted after 2 weeks. Concerns raised after piloting were discussed by the research team, and items were reworded, with some added or omitted as necessary.

The questionnaire collected data on the participants' demographic characteristics, and their experiences of support with their male partners during antenatal care, labour and birth. The demographic data included age, gender, parity, education, occupation and marital status. Then participants were asked if they ever received any support from their male partners during antenatal care and birth and the type of support they were given was probed. Possible types of support included accompanying the participant to antenatal care, participating in HIV testing and providing any financial or material support during antenatal care or birth. For participants who were single, divorced or separated, the 'male partner' was the father of their baby.

The questionnaires were individually administered to women, providing the opportunity for the researchers to clarify the participants' interpretations of the questions, enhancing the validity of the responses. Each woman was interviewed once and each interview lasted for 15–25 minutes. Data were collected in Swahili or English, as preferred by the participants, in a private quiet room at the health facility.

Data analysis

The data were first double entered into Epidata by two data entry operators, then verified for data entry errors and cleaned. The cleaned data was converted for the Statistical Package for Social Sciences (version 23) to analyse frequency distributions. In addition to independent coding and analysis of the collected data (TK, JM), the interdisciplinary research team held analysis meetings to verify the coding framework and make a critical interpretation of the analysed data.

Ethical considerations

Ethical approval to undertake the study was granted by the Moi University and Moi Teaching and Referral Hospital Institutional Review and Ethics Committee. Permission was also granted by the medical officer of health and medical superintendent at Uasin Gishu County Hospital before the study was conducted. Written informed consent was obtained from all participants after an explanation of the study's purpose, benefits and risks. Participants were informed that the study was voluntary and that they could withdraw at any time, although none of the participants did withdraw before the study was completed. Anonymity and confidentiality were assured and maintained by the use of codes in place of participant names.

Results

The participants' demographic characteristics are shown in **Table 1**. Of the 364 respondents, 76% were married at the time of the study. The participants' ages ranged from 18–43 years, with the largest proportion (48.1%) being 25–30 years old. Over half (54.9%) had reached post-secondary education, with four respondents not having attended any formal education. Most women (92%) had had more than one previous live birth.

Male partner involvement during pregnancy

Table 2 outlines the support participants received from their male partners during their pregnancy. Almost a quarter (23.1%) of respondents reported always being accompanied by their male partner to antenatal care clinic appointments, but almost a third (32%) were never accompanied. The majority of respondents reported being given financial support by

Table 1. Demographic characteristics

Demographic	Category	Frequency, <i>n</i> =364 (%)
Age (years)	18–24	106 (29.1)
	25–30	175 (48.1)
	31–36	61 (16.8)
	37–41	15 (4.1)
	>41	7 (1.9)
Education	Primary	29 (8.0)
	Secondary	131 (36.0)
	Tertiary	200 (54.9)
	None	4 (1.1)
Marital status	Married	276 (75.8)
	Single	66 (18.1)
	Divorced	7 (1.9)
	Separated	15 (4.1)
Parity	0	29 (8.0)
	1	142 (39.0)
	2	106 (29.1)
	3	62 (17.0)
	>3	25 (6.9)

their male partners (87.0%), in the form of being bought food (18.1%), fare to travel the health facility (14.0%) or both (54.9%), while 13% did not receive any form of financial support from their male partners.

The majority of respondents (73.9%) received support when they were sick during pregnancy, in the form of either emotional support (14.0%), being taken to the hospital by their male partners or both (36.8%). However, 18.1% did not receive any form of support from their male partners if they were sick.

A large proportion (40.1%) of the respondents did not receive any support with taking nutritional supplements from their male partners, if they needed them. Almost a quarter (23.1%) were supported in buying supplements and 18.1% were reminded to take their pills on time.

Around a fifth (20.1%) of participants were accompanied by their partners for joint HIV testing and counselling, while 22.5% received no support in this area.

Male partner involvement in labour and birth

Table 3 outlines the findings for male partner involvement during labour and birth. In labour companionship, 37.1% of participants reported that their partner took them to the hospital and was present during labour, while 25.0% did not have any partner support either in accessing the hospital or during labour.

For birth companionship, 37.1% of participants reported that their partners were present during the birth and prepared for the baby's birth by buying a layette, while only 12.1% reported that their partner was present during the birth of the baby.

Discussion

This study explored women's experiences of male partner involvement in maternal healthcare at the Uasin Gishu County Hospital, in Eldoret, Kenya. During antenatal care, almost three

Table 2. Male partner support in antenatal care

Nature of support		Frequency, n=364 (%)
Accompanied to antenatal care clinic	Never	116 (31.9)
	Always	84 (23.1)
	Sometimes	135 (37.1)
	Rarely	29 (8.0)
Financial support	Provide fare	51 (14.0)
	Buying food	66 (18.1)
	Both	200 (54.9)
	None	47 (12.9)
Support during sickness when pregnant	Taken to hospital	84 (23.1)
	Emotional support	51 (14.0)
	Both	134 (36.8)
	None	66 (18.1)
	Not sick during pregnancy	29 (7.9)
Support with nutritional supplementation (iron and folic acid)	Buying supplements	84 (23.1)
	Reminders to take supplements	66 (18.1)
	Both	61 (16.8)
	None	146 (40.1)
	Did not need supplements	7 (1.9)
HIV testing and counselling	Accompanied for joint testing and counselling	73 (20.1)
	Taking part in decision making	62 (17.0)
	Both	149 (40.9)
	None	82 (22.5)

Table 3. Male partner involvement during labour and birth

Nature of support		Frequency, n=364 (%)
Labour companionship	Present during labour	29 (8.0)
	Taken to hospital by male partner	80 (22.0)
	Both	135 (37.1)
	None	91 (25.0)
	N/A	29 (8.0)
Birth companionship	Buying baby's layette	106 (29.1)
	Present during birth	44 (12.1)
	Both	135 (37.1)
	None	54 (14.8)
	N/A	25 (6.9)

quarters of participants were never accompanied by male partners, but instead received financial support to buy food, travel to clinics or buy nutritional supplements. During labour and birth, around a third of the participants were accompanied to the hospital by their male partners who were also present during labour.

Less than a quarter of respondents in the present study were always accompanied by their male partner for antenatal care appointments. Almost a third were never accompanied or only occasionally accompanied. A study in western Kenya of 94 men reported that over half of the participants had accompanied their partners to the antenatal clinic, but this mainly took place during late pregnancy (Ongolly and Bukachi, 2019). Male partners infrequently accompanying women to antenatal care clinic appointments has been reported not only in Kenya (Afulani et al, 2018; Ongolly and Bukachi, 2019), but also in other parts of Africa (Morgan et al, 2017; Mersha, 2018; Muheirwe and Nuhu, 2019; Gibore and Bali, 2020; Gopal et al, 2020). African studies have established that prevailing patriarchal community norms and values influence gender roles and lead to low male participation in maternal care (Lowe, 2017; Morgan et al, 2017; Muheirwe and Nuhu, 2019; Gibore and Bali, 2020). In rural areas of Gambia, it has been reported that many men do not believe that pregnancy-related responsibilities warrant their attention, when compared to other social responsibilities (Lowe, 2017). This situation was more common in neighbourhoods where men who helped with house chores were subjected to mockery from their peers (Lowe, 2017). Similarly, in Ghana, it has been established that as heads of the family, men often control resources, consult soothsayers to determine when and how to seek healthcare services for pregnant women and serve as the final authority on where and when pregnant women should seek medical care (Aborigo et al, 2018). Beyond this role, they have no expectation of participating in antenatal care and consider it unnecessary to attend clinic appointments with their partners (Aborigo et al, 2018).

The tendency for men not to be involved in maternal healthcare may also be exacerbated by systemic issues at health facilities. A study in central Tanzania reported that structural constraints affected men's involvement in pregnancy, such as long waiting times for services, the distance to the facility, healthcare providers using insensitive language, small consultation rooms and the lack of privacy in labour wards (Gibore and Bali, 2020). Similarly, inadequate community sensitisation to the importance of male involvement in maternal care was reported to hinder men from participating in antenatal care in west Uganda (Muheirwe and Nuhu, 2019). These findings demonstrate that despite advocacy for male involvement in maternal healthcare by the World Health Organization, the United Nations Population Fund and many non-governmental organisations, male partner involvement is yet to become widespread in African countries. In Kenya, the maternal mortality ratio is 342 deaths per 100 000 live births (World Health Organization, 2019) and most maternity campaigns focus on HIV infections, child nutrition and immunisation. Policy provisions in regard to male participation in maternal healthcare could be improved. For instance, Kenya has a national road map for achieving the 2030 sustainable development agenda related to maternal and newborn health (United Nations General Assembly, 2015). This road map mentions male involvement in maternal healthcare and identifies the lack of male involvement as a key challenge, but fails to prioritise male involvement in its recommendations and intervention strategies.

Most participants in the present study received financial support from their partners to buy food, travel to antenatal clinics or to buy nutritional supplements. Only 13% of respondents reported not being given financial support in any form. Financial support from male partners has been established as a key factor that influences women's ability to access health facilities for maternal care. In Uganda (Morgan et al, 2017), mothers reported not receiving financial support from their male partners and cited lack of male involvement as the main issue when seeking maternal health services. Similarly, a study in Kassena-Nankana, Ghana found that male partners controlled family resources and determined the health seeking behaviour of the expectant mothers (Gibore and Bali, 2020). In patriarchal societies like those that are prevalent in Africa, men are seen as the head of households and control family property and resources. This contributes to why they are typically more actively engaged in maternal care responsibilities that involve the provision of money. However, this control of resources is considered a form of economic domestic

violence against women and adversely affects women's access to health services, educational attainment, social mobility and employment opportunities (Ohlan, 2021).

Although some women in the present study received psycho-emotional support from their male partners, 18% of participants received no psycho-emotional support during pregnancy and were not accompanied to the hospital by their male partners when unwell. More than half of the respondents received support from their male partners in taking iron and folic acid supplements during pregnancy, but 40% did not receive any support with nutritional supplements during pregnancy from their partner. This concurs with focus group discussions conducted in western Kenya with male partners (Ongolly and Bukachi, 2019), where over 75% of male partners were never physically involved in maternal healthcare at the antenatal stage. This was largely attributed to cultural norms and lack of awareness of the role of male partners during pregnancy. Partner support can have a significant effect on adherence to nutritional supplementation during pregnancy, an important element of improving maternal and neonatal outcomes. A study in Pakistan reported that when pregnant mothers had support from their male partners, they tended to take prescribed supplements and were more concerned with adherence to supplement routines (Nisar et al, 2014).

Male partner involvement in labour and birth

Approximately half of the present study's participants were not physically supported by their male partners during labour and childbirth. Around a third of participants were accompanied to the hospital by their male partner, who was also present during labour, while 15% of women did not have any physical partner support in either accessing the health facility or during labour. The most common form of support received was male partners buying a baby layette, but few male partners were physically present during the birth.

This lack of support during labour and birth may be attributed to a number of factors (Singh et al, 2014; Ongolly and Bukachi, 2019; Gopal et al, 2020). Gopal et al (2020) examined male partner involvement in Uganda and identified gaps between policy and practice, reporting that there was insufficient and ineffective communication about a male partner's role. Additionally, health workers were not trained to expect a partner's presence or do anything to include men when they attended the health facility with their pregnant partners (Gopal et al, 2020). Men were not allowed inside the health facility in these cases, as it was not considered convenient for health workers (Gopal et al, 2020). During women's focus group discussions in Uganda, Singh et al (2014) reported that over half of men took their female partners to hospital but would wait outside while their partners gave birth, while others stayed in the village (Singh et al, 2014). The same study reported that men were scared to be near their partners when labour began, as they were upset by seeing their partner in pain and did not want to be near them (Singh et al, 2014). Others said that men will lose the respect of their peers if they stay with a woman during birth (Singh et al, 2014).

Similar findings have been reported in western Kenya, where it was noted that health system-related barriers were prevalent, including a lack of services targeting men, a lack of privacy and space for men at the clinic, negative attitudes from healthcare providers and a lack of emphasis on male involvement (Ongolly and Bukachi, 2019). However, evidence from Cambodia, Turkey, Ethiopia and China indicates that male involvement programmes improve family health (Sharma et al, 2018). The importance of male partner involvement in maternal healthcare cannot be overemphasised.

Women may themselves discourage their male partners from being present during labour and birth. A study in western Kenya established that 63% of women did not desire a companion during labour and birth, because of fears of abuse and a lack of trust in their companions (Afulani et al, 2018). Ongolly and Bukach (2019) identified several barriers to male involvement in labour and birth in western Kenya, including cultural barriers, economic barriers (including low income and the costs of healthcare), health system barriers (such as lack of services targeting men and a lack of privacy and space for men) and a lack of emphasis on male involvement (Ongolly and Bukachi, 2019).

In Kenya, the maternal mortality rate is high, with 488 deaths per every 100 000 live births per year (Kenya National Bureau of Statistics, 2014). This high rate is attributed to

known and preventable causes (World Health Organization, 2015). It has been widely agreed that the leading causes of maternal death are the ‘three key delays’, delay seeking medical care, delay reaching healthcare facilities and delay at the institutional level in providing appropriate care; some of these delays can be linked to men (Thaddeus and Maine, 1994). Despite delays that can be attributed to a lack of male involvement in maternal care, men make key decisions in most African families and control family resources.

Limitations

This study reports quantitative data on the involvement of the male partner in pregnancy, labour and birth, as reported by women. It does not explore women’s attitudes and perspectives on male partner involvement. This study also presents data from a study that was conducted in 2015/2016, as a result of events that prevented the authors from submitting the manuscript for publication. Therefore, these data may not reflect the current status of male involvement in maternity care.

Conclusions

Although male involvement in maternal healthcare is key to improving family health, particularly the health of mothers and newborns, evidence from the present study shows that few men participated in maternal healthcare in Kenya at the time of this study. A number of factors influence male partner participation and the available literature highlights a lack of policy provision for male participation, a lack of awareness on the importance of male participation, the influence of sociocultural norms and health system barriers as key contributing factors that discourage male involvement in maternal healthcare. These gaps must be addressed to improve male involvement and thus improve maternal and neonatal outcomes in Kenya.

Policies should be formulated to encourage male partners to accompany women to antenatal and postnatal care. Healthcare systems and health workers need to be given structured support, including training and guidance, so they are aware of the benefits of male involvement and can accommodate them in the health facility.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

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