FACTORS INFLUENCING MALE PARTICIPATION IN ANTENATAL CARE IN KENYA:

A CASE OF KENYATTA NATIONAL HOSPITAL, NAIROBI, KENYA

BY

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DECLARATION

This report is my original work and has not been presented for the award of a degree in this University or any other institution of higher learning for examination.

…… ……

MARY NUNGARI GATHUTO Date

L50/70541/2011

This research report has been submitted for examination with my approval as the University Supervisor.

…… ……

Signature Date

Mr. Samuel Njuguna

DEDICATION

I most sincerely convey my heart felt gratitude to my husband Henry Mwangi, my children Marcellus and Emmanuel for being very supportive and patient with me throughout my struggle with this work. My appreciation also goes to my mum Agatha Nyawira for her love, inspiration and support throughout my life.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDs	Acquired immunodeficiency syndrome
ANC	Antenatal Care/Clinic
ARV	Antiretroviral drugs
EMTCT	Elimination of Mother to Child Transmission of HIV/AIDS
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPT	Intermittent Preventive Treatment for malaria during pregnancy
KDHS	Kenya Demographic and Health Survey
KNBS	Kenya National Bureau of Statistics
KNH	Kenyatta National Hospital
MDGs	Millennium Development Goals
MI//P	Male Involvement/Participation
NASCOP	National Aids & STIsControl Program
PMTCT	Prevention of Mother-to-Child Transmission of HIVAIDS
RH	Reproductive Health
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infecttions
UNICEF	United Nations International Children Emergency Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
FP	Family Planning

ABSTRACT

Male participation in the Antenatal Care is essential for realization of socio-cultural and economic development. This study sought to investigate the factors influencing male involvement in the care of their pregnant partners.The researcher was guided by the objectives of the study which included: To assess how the socio-cultural factors influence male involvement; To evaluate the economic factors affecting male involvement, To explore how the health related services influence male participation and To assess the clients' level of awareness on the services offered in the antenatal clinic. The significance of the male was noted as he is the head of the house and has strong influence on decision making in his family. This research was guided by use of cross-sectional survey in which both qualitative and quantitative data was collected. Data was obtained by means of questionnaires, interview guides and observation schedules. Questionnaires were used to collect primary data. Secondary data was collected from documented information to support primary data. Systematic random sampling technique was used to select the sample from the target population of expectant mothers in the antenatal clinic at Kenyatta National Hospital to explore their views on why their husbands don't attend clinic appointments with them. The men who accompanied their wives/partners were also engaged in an in-depth interview to examine their reasons for coming to the clinic. The data collected was processed, coded and analyzed using Statistical Package for Social sciences (SPSS). The findings of the research which were presented using tables were that; social cultural factors, economic issues and health related services influenced male particitation in the antenatal clinic. The researcher also found out that the clients were impressively aware of the services offered and other activities carried out in the clinic. The researcher however concluded that there was need for the facility especialy the clinic area to improve in terms of space and sitting arrangements to accommodate all mothers and their spouses comfortably and add more doctors to facilitate quick and quality services to the clients. The researcher also felt tbe need to advocate for policy change so that the government can pass laws which oblige men to be responsible for their unborn babies and their pregnant partners especially financially and emotionally..

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Antenatal care (also known as prenatal care) refers to the regular medical and nursing care recommended for women during pregnancy. Prenatal care is a type of preventative care with the goal of providing regular check-ups that allow doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child.During check-ups, women will receive medical information over maternal physiological changes in pregnancy, biological changes, and prenatal nutrition including prenatal vitamins. Recommendations on management and healthy lifestyle changes are also made during regular check-ups. The availability of routine prenatal care has played a part in reducing maternal death rates and miscarriages as well as birth defects, low birth weight and other preventable health problems.source

Prenatal care generally consists of:monthly visits during the first two trimesters (from week 1–28); fortnightly visits from 28th week to 36th week of pregnancy; weekly visits after 36th week until delivery (delivery at week 38–42) and assessment of parental needs and family dynamic. At the initial antenatal care visit and with the aid of a special booking checklist the pregnant women become classified into either normal risk or high risk.Physical examinations generally consist of: Collection of mother'smedical history; checking their blood pressure; height and weight; Pelvic exam; Doppler fetal heart rate monitoring; blood and urine tests and Discussion with caregiver. Sources

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

Male involvement in reproductive health is a complex process of social and behavioral change that requires men to play a more responsible role in reproductive health. It not only implies contraceptive acceptance but also refers to the need to change men’s attitude and behavior

towards women's health, to make them more supportive of women using health care services and sharing child-bearing activities. Participation of men in reproductive health leads to better understanding between husband and wife, it reduces not only unwanted pregnancies but also reduces maternal and child mortality in connection with pregnancy and labor bybeing prepared in obstetric emergencies (Drennan, 1998).

In South Africa, as in most other African countries, family planning, pregnancy and childbirth have long been regarded as exclusively women's affairs. Men generally do not accompany their partners to family planning, antenatal or postnatal careservices and are not expected to attend the labour or birth of their children. However, male dominance socially and in sexual relations can put women at serious risk of unwanted pregnancy and infection; in pregnancy, male sexual behaviour can affect the health outcomes of both mother and baby.

Their lack of participation at family planning, antenatal and postnatal consultations means that they do not benefit from any information given by health providers, regarding the health of mother and baby, or about their role in it. In addition, men are rarely exposed to clinic reproductive health services as they tend to seek care for sexually transmitted infections (STIs) in the private sector, and condoms can be obtained from clinics without contact with providers. The issue of accessibility of reproductive health (RH) services to men in South Africa is a logistical and cultural problem. The exclusive use of services by women has, to a great extent, made RH services unfriendly for men.

Male involvement in the antenatal care (ANC) clearly goes against prevailing gender norms in many places in Sub-Saharan Africa (SSA). Reproductive health seeking was seen by men as "women's work". Men saw the antenatal clinic as women's space, and the definition and organization of the program as fundamentally female oriented (Reece, et al. 2010). Predictably, men thought that antenatal clinic activities fell outside their area of responsibility. Consequently, men perceived that attending the antenatal clinic would be "unmanly".

According to Byamugisha, et al. (2010), there are different factors which have been identified in other studies as barriers to male involvement in the ANC and they include: Health-facility factors, Cultural factorsand Socio-Economic factors. The failure to incorporate men in maternal health promotion, prevention and care programs by policy makers, program planners and implementers of maternal health services has had a serious impact on the health of women, and the success of programs (Greene, et al. 2002). Yet the huge majority of African women are still

unaware of their fundamental rights to health and they continue to suffer from socio-economic discrimination and unwanted pregnancies which are harmful to their health.

The United Nations expert group on women and finance estimated that 70 percent of the world's population living on less than a dollar a day is women (Were, 2009). Women tend to have less education and have fewer job opportunities,which influence their maternal health seeking behavior and maternal health outcomes. Greater male involvements in maternal health programs may help reduce un-intended pregnancies and transmissions of sexually transmitted infections as well as improve child survival.

According to the data manager's quarterly reports on male uptake at Kenyatta National Hospital (KNH) the records for 2009-2010 was 3078 (34%), whereas for October 2011 to September 2012 was 1694(29%) and for October 2012 to September 2013, 1372(24%). This shows a low and declining trend which needs be addressed.KNH, being a referral hospital, receives many mothers in the ANC from all over the country. There are mothers who come from the rural areas to join their spouses who live in Nairobi at the same time receiving health care services in this hospital. However, only a few are accompanied by their husbands to the clinic to avoid getting lost in the city.The antenatal clnicalso receives clients from the middle income populace since there is a consultation fee to be paid during every visit which many from the low income class may not afford. Again their spouses have busy working schedule making them not attend the ANC with them.

To determine the effect of partner involvement and couple counseling on uptake of interventions to prevent Human Immunodeficiency Virus (HIV) transmission, women attending a Nairobi antenatal clinic were encouraged to return with partners for voluntary counseling and testing (VCT) and offered individual or couple post-test counseling. Nevirapine was provided to seropositive women and condoms distributed to all participants. Among 2104 women accepting testing, 308 (15%) had partners participate in VCT, of whom 116 (38%) were couple counseled. Thirty two (10%) of 314 seropositive women came with partners for VCT; these women were 3 fold more likely to return for Nevirapine and to report administering Nevirapine to the newborn at delivery and five times more likely to adhere to prescribed breastfeeding protocols, accept and modify infant feeding practices and increase condom use in the postpartum period than those who did not (Farquhar, et al. 2004).

1.2 Statement of the problem

Good care during pregnancy is important for the health of the mother and the development of the unborn baby. Pregnancy is a crucial time to promote healthy behavior and parenting skills. Good antenatal care links the woman and her family with the formal health system, increases the chance of using a skilled attendant at birth and contributes to good health through the life cycle. Inadequate care during this time breaks a critical link in the continuum of care, and affects both women and babies.

Men have traditionally not been involved in the reproductive health care of their partners. Therefore, there has been a low and declining rate of male involvement in the antenatal clinic in the whole country which has been a worrying trend in the reproductive health department. According to aNational program report by NASCOP (2014), partner involvement in the antenatal clinic by region was as follows:Central 3%, Western 5.3%, Nairobi 5.2%, Rift valley 4.6%, Eastern 6%, Coast 3.4%, Nyanza 6.4% and North Eastern 2%. Therefore, the average male participation in Kenya being 5.1%.There could be various different factors influencing the male participation in antenatal clinic in the eight regions of the country.

When men miss antenatal appointments; They do not accompany their partners for the consultations which means that they do not benefit from any information given by health providers regarding the health of mother and baby, or about their role in it. The men are mostly absent during labour and delivery yet, there are evidences suggesting that men's presence in the labor room shortens the period of labor and reduce the number of children ever born with low birth weight (Dudgeon, & Inhorn, 2004). The men also do not take up family planning methods leaving their wives to be the sole decision makers of their family size.

They also skip testing for HIV with their expectant wives, which put both the mother and the unborn child at risk of HIV transmission and other STIs. The man could be in a discordant relationship making disclosure a problem thus leading to re-infections. This affects poor adherence on ARV drugs if the mother is HIV positive as she has no support of the husband.Partner notification and treatment for sexually transmitted infections have also remained problematic due to several factors, including poor power relations between men and women, lack of knowledge and men's interest in their partner's reproductive health, and poor couple communication.

Thus, participation of men in reproductive health leads to better understanding between husband and wife, it not only reduces unwanted pregnancies but also reduces maternal and child mortality in connection with pregnancy and labor by being prepared in obstetric emergencies (Drennan, 1998). Therefore, the study seeks to investigate the factors influencing male participation in the antenatal clinic so as to improve the antenatal care services for the family.

1.3 Purpose of the study

The purpose of the study was to investigate the factors influencing male participation in antenatal care in Kenya so as to improve on the reproductive health care leading to a healthy nation.

1.4 Objectives of the study

The main aim of the study was to investigate the factors influencing male participation in antenatal care in Kenya. The objectives of the study were:

i. To assess the influence of socio-cultural factors on male involvement in antenatal care in Kenyatta hospital.
ii. To evaluate the economic factors affecting male involvement in KNH's antenatal clinic.
iii. To explore how the health services in KNH influence male involvement in the antenatal clinic.
iv. To assess the clients' level of awareness on the services offered in the antenatal clinic in KNH.

1.5 Research questions

The study sought to answer the following questions:

i. To what extent is the influence of socio-cultural factors on male involvement in antenatal care in KNH?
ii. How do economic factors affect male involvement in KNH's antenatal clinic ?
iii. How do health services in KNH influence male involvement in the antenatal clinic?
iv. What is the the clients' level of awareness on the services offered in the antenatal clinic in KNH?

1.6 Limitations of the study

The study faced some restraints from the Ethics and Research Committee which delayed the approval of the proposal hence disrupting the expected time of data collection. The researcher got inaccurate information from the respondents who felt the questionnaires were consuming their time or were not willing to disclose some personal information. More so, the geographical expanse of the study area, inadequate financial resources and time constraints impacted on the chances of contacting more respondents.

These limitations were mitigated by making sure that, there was proper sample selection, piloting and careful scrutiny of the perceived parameters of measurement in the data tools, population and sample. Questionnaires and interviews,which helped the researcher to attain maximum information from the mothers and men,were employed with the ultimate aim of reducing financial and time constraints. The investigator emphasized on the importance of giving accurate information so as to inform practice. The researcher also got maximum cooperation from the relevant authorities and finally working closely with the supervisor at every stage to benefit from all the comments and advice towards the success of these endeavors.

1.7 Assumptions of the study

The researcher expected the entire exercise to move on smoothly relying on the maximum cooperation of all those involved. However, it was not the case with some partcipants who felt they were tired and being bothered. That the sample adequately represented the population, the data collection instruments had validity and measured the desired parameters. The researcher assumed that the respondents would truthfully and correctly answer the questions, but in some instances the participants left some questions unanswered and with wrong information.

1.8 Definitions of significant terms

Antenatal Care - Support pregnant women receives from the health provider including Couple counseling and testing and pregnancy care in general

Antenatal clinic - The place where consultations and antenatal profile (blood tests and urinalysis etc.) are done by a laboratory technologist.

Antiretroviral drugs- used in the treatment of HIV infection

Family planning - chosing the number of children in a family and the length of tine between their births

Immunization –a method of stimulating resistance in the human body to specific diseases using micro-organisms that have been modified or killed

Male Involvement/Participation - Incorporating men in the antenatal care services which include counseling and testing, family planning, labor and delivery etc.

Postpartum (postnatal) period –period immediately after child and extending for about six weeks

Prevention of Mother to Child Transmission - Interventions given by the health providers to the antenatal mother who is HIV positive e.g. provision of ARV/ART, infant feeding options, sero-status disclosure to the partner and adherence counseling

Prophylaxis – short–term antiretroviral treatment

1.9 Organization of the study

This research study was captured in five chapters. Chapter one provided information which introduced the study. In chapter one, the following were discussed; the background information to the study; statement of the problem; purpose of the study; objectives of the study; assumptions to the study; limitations and delimitations to the study; and definitions to terms used in the study. Chapter two discussed the literature from previous studies and some empirical evidence based on the concerns and objectives of the study. This chapter provided summary of the literature and knowledge gaps, the conceptual framework to the study. Chapter three provided a description to the methodology that was used in this study. These descriptions involved information on; research design; target population; sample size and sampling procedures; data collection instruments; data collection procedure; validity and reliability of the data collection instruments and data analysis techniques. In Chapter four the data was analyzed, presented, interprated and discussed using percentages and tables. Finally chapter five completed the study with summaries of findings, conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter dealt with the review of related literature of the study. Past studies done on male Involvement in the antenatal clinics were reviewed to identify the existing gaps which the study tried to address. The conceptual model was discussed to give a good highlight.

2.2 Accessibility and utilization of maternal health services by women

The goal of maternal health care services is to ensure that no woman or newborn dies or incurs injuries due to pregnancy and or childbirth. However to achieve this goal, maternal health service planners, service managers and providers need to view maternal health services in the context that women's potential to control and improve their wealth as well as their health is more limited than men's in most parts of the world (*Engender Health*, 2008). This prevents women from accessing critical health information and services and can lead to poor reproductive, maternal and child health outcomes, including unwanted infections and unwanted pregnancies.

For men have a strong influence on women's health and their access to care, the need for male involvement in maternal health services is clear and male involvement is becoming even more critical in the delivery and uptake of maternal health care service. According to Adamehak and Adebyao (1997), in order to encourage improved reproductive health, emphasis needs to be focused on the understanding of men's reproductive behavior and the influence to their wives.

2.3 Male participation in the Antenatal Clinic

It is important to note that to increase male involvement in maternal health care services requires the providers to gain in-depth knowledge and understanding of the men's health perspectives, behavior and practices. Although pregnancy is not an illness, it creates a lot of physical and emotional demands on the mother. The husbands as well as other family members need to understand and appreciate the discomfort and tiredness that pregnancy may cause to the pregnant woman. The awareness about the demands of pregnancy on the part of the husband and other family members could result into the necessary support the pregnant woman needs from the family members including the husband.

The key elements of the birth plan package include recognition of danger signs, a plan for a

birth attendant, a plan for the place of delivery, and saving money for transport or other costs in case the need arises. In addition, for birth preparedness, a potential blood donor and a decision-maker (in case of emergencies) need to be identified. This is because complications such as hemorrhage are unpredictable and highly fatal if timely treatment is not obtained. Essential interventions in antenatal clinic include identification and management of obstetric complications such as pre-eclampsia, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy (IPTp), and identification and management of Infections including HIV, syphilis and other sexually transmitted infections (STIs). ANC is also an opportunity to promote the use of skilled attendance at birth and healthy behavior such as breastfeeding, early postnatal care and planning for optimal pregnancy spacing.

Globally, low male involvement in maternal health care services remains a problem to health care providers and policy makers. Since the Cairo International Conference on Population and Development, (ICPD) (1994), and the Beijing World Conference for Women (1995), a lot of emphasis has been to encourage male involvement in reproductive health including maternal health (WHO, 2007). At the 1994 ICPD in Cairo the participating nations (179 nations) agreed on the action plan, which stated that "Changes in both men's and women's knowledge, attitudes, and behavior are necessary conditions for achieving a harmonious partnership between men and women on issues of sexuality and reproductive health" (UNFPA, 2004:29).

In sub-Saharan Africa, pregnancy and childbirth continue to be viewed as solely a woman's issues. A male companion at antenatal care is rare and in many communities, it is unthinkable to find male companions accompanying a woman to the labour room during delivery. However, men have social and economic power, especially in Africa, and have tremendous control over their partners. They decide the timing and conditions of sexual relations, family size, and whether their spouse will utilize available health care services . Hence this situation makes male partner involvement critical if improvement in maternal health and reduction of maternal morbidity and mortality is to be realized.

Strategies for involving men in maternal health services should aim at raising their awareness about emergency obstetric conditions, and engaging them in birth preparedness and complication readiness. Male involvement will enable men to support their spouses to utilize emergency obstetric services early and the prepare for birth and ready themselves for complications. This would lead to a reduction in all three phases of delay and thereby positively impact birth outcomes (kakaire, et al, 2011)

Studies have shown that men who are educated about reproductive health issues are more likely to support their partners in contraceptive use, use contraception themselves, and demonstrate greater responsibility for their children (Grady et al. 1996). More importantly, women express great interest in wanting their partners to be involved in joint reproductive health decision-making. For example, a study in Ecuador surprisingly showed that 89% of women wanted their partner to accompany them on their next family planning visit and 94% would have liked their partner to be present during their family planning session (Roy & de Vargas Pinto, 1999; Mehta, 2002). Studies have suggested that male involvement in maternal health results into positive outcome for not only the pregnant woman but also for the unborn child. Reporting findings of their studies Pagel et al. (1990), and Mutale et al. (1991), concluded that lack of social support; especially from the husbands or family has negative effects on fetal growth.

In much poorer countries many of which have a patriarchal society, increase in male involvement during pregnancy has been seen as a possible factor in reducing the number of children born with low birth weight (Mira and UNICEF, 2000). However despite these benefits of male involvement in maternal health care services, the majority of interventions and services to promote SRH including care during pregnancy and childbirth in most countries have been exclusively focused on women (Ntabona, 2002). Yet it is important to assume that for all the steps leading to maternal survival there is always a man standing by the side of every woman knocking at the gate, before, during and after each pregnancy (WHO, 1995).

Some 24 studies from peerreviewed journals; 21 from sub-Saharan Africa, 2 from Asia and 1 from Europe identified barriers to male involvement as mainly at the level of the societal perception of antenatal care (ANC) as a woman's activity, and it was unacceptable for men to be involved, the health system factors such as long waiting times at the ANCS and the male unfriendliness of ANC services were also identified. The lack of communication within the couple, the reluctance of men to learn their Human Immunodeficiency Virus (HIV) status, the misconception by men that their spouse's serostatus was a proxy of theirs, and the unwillingness of women to get their partners involved due to fear of domestic violence, stigmatization or divorce was among the individual factors.

According to World Health Organizations (WHO, 2007), the Partnership for Maternal, Newborn and Child Health (PMNCH) reports showed that in Swaziland, HIV prevalence among pregnant women attending ANC arose from 4% in 1992 to 43% in 2004 and that each

day, 1800 children worldwide become infected with HIV, the vast majority of them newborns. Therefore, in this regard, PMNCH works to invest, deliver and advance to save lives of women and young children with HIV/AIDS.To achieve all these fundamental goals effectively and quickly, investing in the education and involvement of men during/after pregnancy and in programs for mothers living with HIV.AIDS is very crucial. Moreover, there is need to advance the engagement of men in the ANC as PMTCT efforts may fail without their support."When men test, adherence to PMTCT may increase" (Msuya et al. 2008). One study has demonstrated a reduction in HIV-associated infant mortality and poor feeding options (Aluisio et al. 2011). Male-partner involvement may also lower transmission risk to sexual partners, which has been shown to be greatest within established partnerships (Dunkle et al. 2008), and increased during pregnancy (Mugo et al. 2011).

In a study which examined the male spousal participation in Western Kenya, of 2104 pregnant women who accepted voluntary counseling and testing (VCT), 15% of these women and their male spouses received testing, while only 5% of couples received counseling together (Farquhar et al.2004). Male partner support has been shown to be a crucial component in facilitating women's ability to accept preventive interventions. Women who disclosed their HIV status to their partners were more likely to return for post-test counseling, three times more likely to adhere to their ARV prophylaxis/ treatment during pregnancy and at the time of delivery, and five times more likely to adhere to prescribed breastfeeding protocols, accept and modify infant feeding practices and increase condom use in the postpartum period than those who did not (Farquhar et, al. 2004).

Men are clearly asking for more participation in the childbirth process. It is also interesting to note how, in a recent survey on men and work, 75% of the men would accept slower career advancement if they could have a job that would let them arrange their work schedule to have more time with their families. At the prospect of becoming a father, men are filled with excitement, fear, wonder, worry, love, and confusion. Throughout the pregnancy and birth, the man, who is now becoming a father, is trying to find ways to express and integrate these and many more feelings. In contrast, other programs have been successful in achieving greater participation of couples during expanded weekend hours (Allen et al. 2003).

By giving women emotional and instrumental support, men can also clearly positively affect women's attitude towards pregnancy (Kroelinger & Oths, 2000). During pregnancy and delivery men can give important psychological and emotional support to the women (Early,

2001). There are evidences suggesting that men's presence in the labor room shortens the period of labor and reduce the number of children ever born with low birth weight (Dudgeon & Inhorn, 2004).

Byamugisha et al. (2010), scored male involvement using 6 variables: The manaccompanying his wife during ANC services; knowing the ANC schedule; discussing the ANC interventions with the female partner; supporting the ANC fees; Knowing what happens at the ANC and Using a condom with the female partner during the current pregnancy. Scores between 0–3 were considered weak male involvement and scores of 4 and above were considered as high male involvement. While this scoring system is a useful first step, it remains to be validated

2.4 Factors influencing Male Participation in the Antenatal Clinic

2.4.1 Social and cultural factors

Social scientists have made significant strides in shedding light on the basic social and cultural structures and processes that influence health. Social and cultural factors influence health by affecting exposure and vulnerability to disease, risk-taking behaviors, the effectiveness of health promotion efforts and access to, availability of, and quality of health care. Social and cultural factors also play a role in shaping perceptions of and responses to health problems and the impact of poor health on individuals' lives and well-being. In addition, such factors contribute to understanding societal and population processes such as current and changing rates of morbidity, survival, and mortality. (National institiute of health, 2014)

According to a survey done in Mbale regional referral hospital in rural Eastern Uganda and other studies, the following factors were cited as the barriers to male participation.

Age and marital status: Most studies reported that older age and cohabiting were associated with male involvement. A group conducted a study in Kinshasa and found male involvement was 1.2 times higher among men whose female partners were 25 years or older. Monogamous partners and cohabiting men were twice and 1.6 times respectively more likely to beinvolved. In contrast, Nkuoh et al. ( ), reported that Cameroonian men in polygamous relationships showed higher involvement.

Education: A study in Uganda found that men who had completed 8 or more years of education were twice more often involved compared with those with less than 8 years of education. This was not confirmed in a study in Kinshasa where the level of education of

pregnant women or their male partner did not influence male participation.

Profession: In Uganda, taxi drivers and "Bodaboda" riders (motorbike taxi riders) were less likely to participate than men with other professions such as farmers or construction workers. Reece et al. reported that Kenyan men having only an occasional job were less likely to participate in MCH services. Another study from Rwanda reported that men with a well-paid job were more likely to participate in PMTCT interventions compared to those not well paid

Culture: In several studies cultural standards were identified as barriers for male involvement. Several studies have reported negative perceptions towards men attending ANC services. In one report, men who accompanied their wives to ANC services were perceived as being dominated by their wives or weaklings by their peers. Frequently men perceive that ANC services are designed and reserved for women, thus are embarrassed to find themselves in such "female" places.Some men believe it is not good to follow your wife to the antenatal clinic even though she exposed her privacy to you at home and that male participation in ANC services is superfluous and that ANC is "a woman's responsibility" (Byamugisha et al. 2010). Certain women too, do not like to be seen with their male partner attending the ANC service. A study conducted in Kenya showed that certain male clients trust traditional healers but not hospitals and therefore do not attend ANC clinics.

Male attitudes and beliefs: Fear of receiving a HIV positive result and confidentiality concerns prevent some men from coming for ANC. In many studies men were mentioned being concerned about HIV-associated stigma and disclosure. Men may be afraid of HIV status disclosure in a health system facility, in the context of weak health system. In another study, women said that engaging their partners in PMTCT would be particularly challenging if men were unaware of their status, refused to be tested, or were in denial about their HIV status (Reece et al. 2010). There also seems to be a gap in knowledge related to discordancy. Some men questioned the need for testing if their partners had already been tested, believing that they would have the same test results as their partners (Falnes et al. 2011). Men also feared discordancy because of the anger and bitterness it could cause in the relationship.

Female attitudes and considerations: Gender-based violence is another cause of low male involvement. Victims of gender based violence may be afraid to ask their partner to be tested for HIV. Several studies also have showed that women at ANC clinics fear violence from their partners who attend ANC clinics with them. These women feared how their partners would

react after the discovery of a positive HIV test result which may lead to abandonment, loss of economic support, fear of stigmatization, rejection, discrimination, violence, upsetting family members, and avoiding accusations of infidelity (Medley et al. 2004).

Alcohol use was identified as another factor for non-participation of men. Daily overconsumption of alcohol by male partners maybe particularly implicated as a catalytic event for physical violence towards women. In similar regard, Karamagi reported alcohol as one of reasons for 54% of lifetime partner's violence and 14% of physical violence in Uganda. Ntanganira found the 35.1% of intimate violence in the last year; physical violence was twice likely to occur if a woman was HIV positive than negative.

Communication: Poor communication between men and their female partners was associated with poor male involvement. On the other hand, good couple communication was associated with high seropositive status disclosure and support between husband and wife. For instance, in this study the focus of involvement of men in antenatal care was on their readiness to provide support to their female partners in core PMTCT interventions which include counseling and testing, use of prophylaxis antiretroviral drugs and choice of baby's feeding options (Shaffer et al. 2000:1180).

Participation increases spousal communication about sexual risk and behavour change (Desgrees-du-Lou et al. 2009a). This becomes especially critical in discordant couples, where men's involvement in testing may enable the couple to address condom use, decrease sex with outside partners and thus help to prevent HIV and other STI transmission to the uninfected partner (Roth et al. 2001; Allen et al. 2003). Studies have also shown an association between men's involvement and contraceptive use (Becker, 1996; Sternberg and Hubley 2004).

2.4.2 Economic factors

Financial constraints: Financial constraints of clients and health facilities have been identified as impacting health services uptake and male participation. A Ugandan study reported that some health providers charged extra beyond the official ANC fees to bridge their own financial gaps while other authors have identified low health providers' salaries as limiting factors for male involvement.

A qualitative study conducted in western Kenya by Reece found that the distance that the male partners have to travel to the clinics for participating in the education, blood tests and

counseling, the costs of the transport to the clinics and the amount of time per appointment at the clinic were identified as barriers to male involvement. Access or logistical challenges on the part of men prevented them from participating in ANC. Men talked about their perceived principal responsibilities as providers. Thus, time spent at clinics and away from work or other income generating activities was clearly perceived as a barrier to their participation in ANC program Distance, the cost of transport and the clinic operation hours were also mentioned with some frequency (Reece et al. 2010).

Data from another study from Uganda showed that majority of participants said that the health facilities were few and located far from the people, making the health services such as counseling and testing inaccessible. Most of the male partners and men in general preferred the health services to be implemented and extended to their villages or close to their homes in order to save them the costs of time and travel fee.

2.4.3 Health services factors

Behavior and language use: Byamugisha et al. (2010), reported that harsh, critical language directed at Ugandan women from skilled health professionals was a barrier to male participation. Harsh treatment of men by health providers discouraged them from returning or participating in antenatal activities. Furthermore, some providers did not allow men access to clinic settings. Men mentioned the negative attitudes of staff members: "Staff members' lack of common courtesy, their "rough handling" of pregnant women and health-care workers not allowing men to enter the antenatal clinic with their partners".

In fact, men experienced healthcare workers who were reluctant to encourage male attendance in antenatal care at all, felt unwelcome and disrespected and thought it was clear that services were designed without taking their particular needs into consideration. The charging of unofficial user fees was another barrier cited, the lack of integration of services was mentioned as discouraging men from getting tested, since they felt they would be "exposed" through special clinics or opening hours (Larsson et al. 2010).

Venue and space constraints: In a study in the DRC, men were invited for voluntary counseling and testing (VCT) in three venues: a bar, a health center or a church. Male involvement in VCT was higher in the bar 26.4% and church 20.8% compared to the health center 18.2%. These results suggest that more friendly and convenient venues for men are needed. The lack of space to accommodate male partners in ANC clinics was also reported to

adversely impact male involvement. Clinics are often unable to concurrently accommodate pregnant women and their partners because of a lack of space. Gender specific services to address uniquely male issues do not exist. Targeted interventions for men, such as tailored messages, specific health education sessions, and innovative strategies to identify male friendly venues would be valuable for increasing male involvement.

Waiting time: Frequently women have to wait for a long time before receiving ANC services because of burdensome administrative procedures which result in poor patient/client through-out the health facilities. Men, who are in the paid workforce, are often not in a position to spend virtually the entire day participating in ANC services.

Quality of care: In a study in Rwanda, it was shown that essential services were often not proposed by health providers thus contributing to the weak ARV prophylaxis uptake among clients and poor appointment schedules. Health services providers are often overworked stressed getting burn-outs and have to work in an infrastructure with severely limited resources. In such context, the quality of services is compromised and taking care of participating male partners is considered an additional burden.

Time of day for providing ANC services: Increased male participation in the antenatal series occurred in Kinshasa when the MCH services are open in the evenings between 5:00 – 8:00 pm and at weekends. Most health facilities offer these services only on weekday mornings, when the majority of men are at work. Yet several studies have identified ANC opening hours as a limiting factor for male involvement. Geographical constraints impact health services uptake and male participation. Lack of decentralized services is a reason for low health services uptake and limited male involvement.

Dominance by female staff: Most clinics are dominated by female staff and patients, which can be off-putting for men. At the male health centers positive men form support groups and both reactive and non-reactive men are counseled on the importance of accompanying their partners for antenatal visits. The men also receive education on issues that are usually taboo for men such as the importance of exclusive breastfeeding for seropositive mothers.

2.5 Suggestions given for improving male involvement

The study conducted in Mbale district, Uganda gave the following suggestions: Sensitizing men about antenatal services and their benefits, conducting refresher courses for midwives and

nurses where the respondents suggested that retraining of the health-care providers should include customer care skills, the government to build more health units closer to the people where antenatal care could be offered, welfare of the staff to be improved e.g. provision of better remuneration, more staff to be recruited into the health service and midwives to write on the antenatal cards informing the men to come with their wives on subsequent ANC visits.

2.6 Conceptual Framework

According to Reichel and Ramey (1987) a conceptual framework is a set of broad ideas and principles taken from relevant fields of enquiry and used to structure a subsequent presentation. It is a research tool intended to assist a researcher in developing an understanding of the situation under investigation. The study utilized conceptual framework illustrated below in order to meet the objective of the research. Male participation was conceptualized as being dependent on factors like health service factors, socio-cultural factors, economic factors and level of awareness.

2.6.1 Socio-cultural factors

These factors include marital status, education, communication, cultural beliefs and traditions.The men who are more educated have a high probability of attending the ANC probably because of exposure and awareness. More so, men in lower professions are less likely to accompany their partners for antenatal appointments because they could lose their day's pay as expectant mothers spend so much time in the clinics, others complain of the distance of the health facility which consumes a lot of money on transport for two people. Men are also perceived as weakling or dominated by their wives if they accompanied them to the clinic. Some women do not want their husbands around as theyfear the outcome of a HIV positive result which would lead to rejection, abandonment and financial deprivation or even domestic violence.

2.6.2 Economic factors

These include financial constraints which may affect male attendance. The men being the breadwinners have busy schedules. Some of them are on contract or casual jobs,with very uncompromising bosses. Absenteeism therefore may mean no income for that day, or in extreme cases, loss of the job.

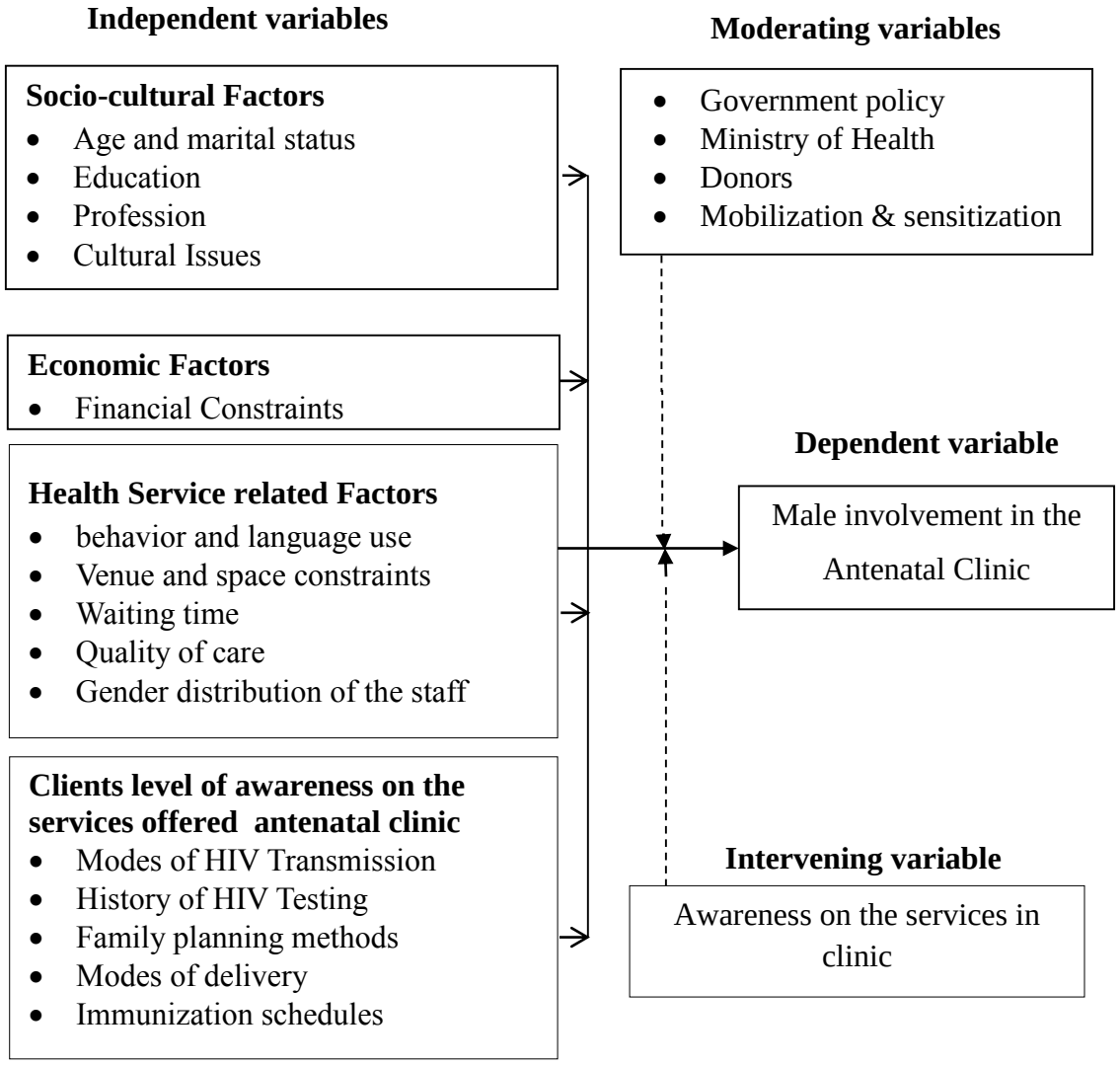

Figure 1: Conceptual Framework

2.6.3 Health Service factors

These include behavior and language use, venue and space constraints, waiting time, quality of care, Time of day for providing ANC services, Dominance by female staff. The health providers are mainly female and more to that use harsh language to both pregnant mothers and the men in the clinic. This makes the men to wait outside the clinic for their wives to attend their services or even leave for work. Further, some men felt some health providers were few to handle the huge numbers, hence overworked and addition of the male in the clinics was a burden to them thus experiencing burn-out. The small space in the clinics is also not accommodative to both expectant mothers and their husbands. Some men felt that the clinic days and hours should be changed to suit their busy working schedules, i.e. the services to start

after work, at 5pm or be moved to the weekends when most are available or have a flexible time frame.

2.6.4 Clients awareness on the services offered in the antenatal care

Men should accompany their wives in the antenatal clinic where there are different services offered including family planning methods, pregnancy and birth preparedness, immunization schedules, counseling and testing and other observations. The researcher wants to know if these men and mothers know and undetstandabout these services and if they make an impact on the client's clinic attendance and adherence to thedoctor's appointments.

2.7 Summary of the literature review and knowledge gap

Convincing men to attend the antenatal clinic with their partners is one of the gaps which were identified by this study while reviewing the past studies. All the independent variables are seen to influence the dependent variable and the outcomes of those studies will either be positively or negatively related. Literature review is important for any research to be undertaken because it gives the researcher a direction and instances of comparisons.Therefore, it was paramount for the researcher to review all the related litratures of the study under course.

Most of the available information regarding men and ANC relates to HIV testing and general PMTCT component. More research is needed regarding ways to involve men in the other servces offered in the antenatal clinic like the family planning, immunization etc. There was hardly any mention of men's participation in birth-preparedness planning, the promotion of facility-based deliveries and HIV transmission. There was inadequate research on the role of routine antenatal syphilis screening in engaging men in a woman's pregnancy and the potential influence that STI screening could have in increasing testing coverage of male partners and identifying women at increased risk of HIV acquisition.

Men's use of women as proxies for their own testing suggested limitations in men'sunderstanding of the dynamics of transmission and sero-discordancy. Most of the available information about men and antenatal care came from women and lesssons from men who attend clinic. There was little information about men and couples who did not utilize these services.

Research on HIV risk management and prevention within couple relationships should be strengthened. In sub-Saharan Africa, there is still inadequate socio-behavioural knowledge of HIV prevention within the dynamics of couple relationships (Painter, 2001). This includes

couple communication on sexual risk; the evolution of preventive behaviours over time (e.g. by duration of relationship and time since VCT); and gender issues of negotiation and violence (Desgrees-du-Lou and Gliemann, 2008). Research on the difference between couples who utilize services and those who do not would be useful. What is the relationship between couple quality, utilization and male involvement? Is couple connectedness a confounding factor between utilization and health or behavioural outcomes? These are some of the questions the researcher thought needed answers and probably by conducting another research to find out the outcomes.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the methodology that the researcher used to find answers to the research questions. It sets out various stages and phases that were followed in order to complete the study. It involves a blueprint for the collection, measurement and analysis of data. In this section the researcher identifies the procedures and techniques that were used in the collection, processing and analysis of data. Specifically, the following subsections are included; research design, target population, data collection instruments, data collection procedures and finally data analysis**.**

3.2 Research design

his study was guided by a cross-sectional survey research design. This design is ideal for such a study where sampling from a specific population is done at one point in time (Wiersma,1986). The design allowed collection of data to be done under natural setting, and was relatively quicker and cheaper to undertake and the results were easily inferred to the larger population. Its application allowed for collection of both qualitative and quantitative data from the antenatal clinic. A descriptive survey research seeks to obtain information that describes existing phenomena by asking individuals about their perceptions, attitude, behavior or values. The descriptive approach will also allow the findings of the study to be presented through simple statistics, tables, mean scores, percentages and frequency distributions (Mugenda & Mugenda, 2003). The study described the practices, attitudes, beliefs, challenges and suggestions regarding the male participation in the antenatal clinic.

3.3 Target population

Ngechu (2004), defined a population as a well-defined or set of people, services, elements, and events, group of things or households that are being investigated. This study targeted 2110 expectant mothers in the antenatal clinic at KNH to explore their opinion on their husbands' attendance for the antenatal clinic appointments. Men who also accompanied their wives/partners to the clinic were also engaged in an in-depth interview to examine their reasons for being in the clinic.

3.4 Sample size and sampling technique

Cooper and Schindler (2000), state that the sample size is the selected element or sub-set of the population that is to be studied. To ensure that the sample accurately represents the population, they further recommend that the researcher must clearly define the characteristic of the population, determine the required sample size and choose the best method for selecting members of the sample from the larger population.

Table 3.1 Mothers enrolled in the Antenatal clinic in KNH from Jan-April 2014

Months	Accompanied mothers	Unaccompanied mothers	Total population
Januaary	72	2330	2402
February	93	1877	1970
March	148	1620	1768
April	154	2146	2300
Total	**467**	**7973**	**8440**
Average monthly	**116.75**	**1993.25**	**2110**

Table 3.1 above shows the number of mothers enrolled in the antenatal clinic at KNH in the months of January to April. The average monthly attendance of the expectant mothers in tne four months was 2110 thus, this was the population the researcher targeted to get a sample from. Mugenda and Mugenda (2003), argue that for a sample to be representative enough,it should be atleast 10% of the target population. The researcher's sample size was 211 mothers and were selected using systematic random sampling technique. With the number of male involved being low (5.1%) nationally as reported by NASCOP (2014), and as also shown in the above Table, the researcher used purposive sampling to select the men who accompanied their wives/partners to the clinic for an in-depth interview during the time of study. This helped the researcher to explore men's view on antenatal clinic attendance with their partners.

3.5 Research instruments

The researcher collected the data using open ended and closed ended questionnaires and one to one interview. The questionnaire was designed to collect qualitative and quantitative data whereas one to one interview was conducted using prepared schedules. The structured questionnaires were used to save time and money as well as to facilitate an easier analysis as they were in immediate usable form; while the unstructured questionnaire was used to

encourage the respondent to give an in-depth and felt response without feeling held back in revealing of any information.

3.6 Data collection procedures

Data collection was done by the investigator assisted by two trained research assistants. Informed consent was administered to the men andwomen whomet the criteria of the study. Those who agreed to participate in the study were enrolled after signing an informed consent form. The consenting process included, giving general information on the study, the risks and benefits associated with the study, confidentiality and the partaker's freedom to decline to participate in the study.

The consenting clients were enrolled into the study and then interviewed using structured questionnaires. The questionnaires collected data on male involvement in the antenatal clinic. Every file for the participating mothers and the file for the women whose husbands were participating in the study were marked with a unique identifier after interviews to ensure there would be no repeat interviews on the same clients in the subsequent visit. A red sticker with study number was used for unique identification of patients after the interview. The sticker was placed inside the top cover of the file. Also, a daily log of out-patient number, the name and the study number assigned to each mother enrolled were be kept to countercheck when doing subsequent interviews.

The investigator ensured that the data collected was of high quality by checking through the questionnaire immediately, where any missing or unclear responses to the questions was corrected by requesting the client for additional time to clarify the responses before the study participant left the hospital. A pilot study was done before the actual data collection on a few respondents who were excluded from the final research. This helped in finding out whether the data collection tools were effective. The pilot study was done to establish whether the tools were measuring what they were intended to. The pilot study was conducted to shed light on whether the respondents interpreted all the questions in the same way and necessary amendments were made. Consequently this upgraded the reliability and validity of the study instruments.

3.6.1 Validity of the questionnaire

According to Somekh and Cathy (2005), validity is the degree by which the sample of test items represents the content that the test is designed to measure. According to Mugenda &

Mugenda (2003), validity means that the research findings truly represent the phenomenon the study is trying to measure. They contend that the usual procedure in assessing the content validity of a measure is to use a professional or expert in a particular field. To establish the validity of the research instruments, the researcher sought opinion of the supervisor and conducted a pilot study. This facilitated the revision and modification of the research instruments thereby enhancing validity.

3.6.2 Reliability of the instrument of the study

Reliability is the measure of the degree to which research instruments give similar results over a number of related trials producing similar results consistently. A pilot study was carried out to test the correlation of the responses for consistency and hence reliability. To free the data collection tools from unreliability and misinterpretation, the study carried out a test-retest before applying the research tools in order to test reliability. It was projected that initial responses to the questionnaires would help in re-wording the questions to avoid inconsistency. Any items missing in the questionnaire was added and the unsuitable ones eliminated.The pilot study aimed at determining the reliability of the questionnaires including the wording, structure and sequence of the questions (Ngechu, 2004).

3.7 Data analysis

The researcher edited, coded and analyzed the data through the use of descriptive statistics such as measures of central tendency, frequencies and percentages. In addition to this, computer application package SPSS was used in the analysis of information and reporting of data. The researcher used tables to present the analyzed data.

3.8 Ethical considerations

The main ethical issues which were observed and considered in this study were that the researcher would obtain a letter from University of Nairobi allowing her to undertake the study and an introductory letter explaining the purpose of the study. Approval to conduct the research was also sought from the KNH/UoN Ethics and Research Committee (ERC). Consent was obtained from the participants after explaining to them about the study. The participants were given an opportunity to have their concerns addressed before participating. Participants had the right not to take part in the study. Those who declined to take part had equal access to health services compared to those who accepted.There was no perceived risk involved pertaining the study. Anonymity and confidentiality were ensured by making the questionnaires anonymous.

3.9 Operational definition of variables

Table 3.2 Operationalization Table of Variables

Research Objective	Variable	Indicator	Measurement Scale	Data collection Tools	Type of analysis
To assess the influence of socio-cultural factors on male involvement.	Socio-cultural factors	• Education level • Cultural Beliefs	Nominal scale	Open and closed ended Questionnaires	Descriptive statistics
To evaluate the economic factors influencing male involvement	Economic factors	• Finances • Employment • Salary Scale	Nominal scale	• Interviews • Open and closed ended Questionnaires	Descriptive statistics
To explore how the health services influence male involvement	Health service factors	• Health care providers • public relation • Venue and space in the clinic	Nominal scale	• Interviews • Open and closed ended Questionnaires	Descriptive statistics
To assess the clients' level of awareness on the services offered in the antenatal clinic	Awareness of the importance of antenatal care	• Importance of testing for HIV • Mode of delivery • Family planning methods	Nominal scale	• Interviews • Open and closed ended Questionnaires	Descriptive statistics

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION

4.1 Introduction

This chapter presents analysis and findings of the study as set out in the research methodology. The study aimed at investigating the factors influencing male participation in antenatal care. The researcher targeted a sample of 211 antenatal mothers attending ANC clinic in Kenyatta National Hospital (KNH). Out of 211 respondents, 200 participated by completing and returning the questionnaires and this was a 94.79% response rates. This response rates were sufficient and representative and conforms to Mugenda and Mugenda (1999), stipulation that a response rate of 50% is adequate for analysis and reporting. A response rate of 70% and over is excellent. This commendable response rate was due to constant reminder to the respondent to fill-in and returns the questionnaires.

4.2 Questionnaire return rate

The study had targeted 211 respondents out of which 200 respondents filled and returned their questionnaires. This constituted to 94.79% response rate which was a reasonable rate for the study. Data analysis was done through Statistical Package for Social Scientist (SPSS). Frequencies, percentages and mean were used to display the results which were presented in tables.

4.3 Influence of Socio-Cultural factors on male involvement in the antenatal clinic

4.3.1 Demographic characteristics

The mothers interviewed had a mean age of 28.6 years ranging between 19 to 44 years, while the men had a mean age of 31.81 years.

Table 4.1

Age group of mothers	Frequency	% of Respondents
<25	19	9.5
25-29	59	29.5
30-34	93	46.5
35-39	25	12.5
40-44	4	2.0

Total	**200**	**100.0**

Table 4.1 above and Table 4.2 below shows the Ages of the mothers and the men in the clinic who parcipated in the study respectively.

Table 4.2

Age groups of male partners	Frequency	% of Respondents
25-29	5	23.8
30-34	11	52.4
35-39	3	14.3
40-44	2	9.5
Total	**21**	**100.0**

The marital statuses of the respondents were presented in Table 4.3 below where 89.5% of the women were married and a half had never had a child before the index pregnancy. 18% of the mothers were single whereas 3% were separated from their partners. Perhaps the 18% single mothers indicated one of the reasons there are few men in the clinic. 100% of the men in the study were married while 38.1% had at least one child.

Table 4.3

Marital status	Frequency	% of Respondents
Married	179	89.5
Separated	3	1.5
Single	18	9.0
Total	**200**	**100.0**

4.3.2 Education levels of participating mothers' partners

Mothers (68.5%) had a tertiary level of education whereas 66% of their partners' mentioned having had the same level as shown in Table 4.4

Table 4.4

Husbands level of education	Frequency	% of Respondents
University/College	132	66.0
Secondary school	36	18.0

Primary school	9	4.5
Not indicated	23	11.5
Total	**200**	**100.0**

This created the impression that the clients are likely to take up the services offered in the clinic with ease with an assumption that they are exposed and more so, perhaps explaining why there was a 98.52% response rate, giving their views on how to improve male participation among other information.

4.4 Influence of Economic factors on male involvement in ANC

Less than a half (41%) of the mothers had employment and 31.5% earned below Kshs. 30,000. The women's partners were mainly employed (42.5%) or in business (39%) as shown in Table 4.5 with majority 39.5% of them earning below Kshs. 30,000. This information coming from the mothers could perhaps give reasons why men do not come to the clinic since they are busy at their working stations or in their businesses making ends meet.

Table 4.5

Partner's occupation	Frequency	% of Respondents
Employed	85	42.5
Businessman	78	39.0
Unemployed	12	6.0
Not indicated	25	12.5
Total	**200**	**100.0**

20.5% of the mothers' partners earn between kshs 15,001 and 30,000 thus could be couples in a financial instability. This is revealed in Table 4.6 below with salary ranges.

Table 4.6

Salary scale for husband	Frequency	% of Respondents
Over 80,001	2	1.0
60,001-80,000	12	6.0
30,001-60,000	19	9.5
15,001-30,000	41	20.5
Below 15,000	19	9.5

Not Indicated	10	53.5
Total	**200**	**100.0**

4.5 Influence of Health Services on male involvement in the ANC

4.5.1 Attitude of health care providers to clients

Table 4.7 below shows the judgement of the health providers attitudes by the clients where 63% of the mothers said that the staffs used harsh language, were rude and ignorant.

Table 4.7

Attitude of health care providers	Frequency	% of Respondents
Good/friendly/kind	92	41.0
Approachable	15	7.5
Ignore clients/rude/cruel	63	31.5
Helpful when in good moods	5	2.5
Wanting attitude	12	6.0
Not indicated	13	6.5
Total	**200**	**100.0**

Five percent said that the healthcare providers helped clients only when they were in good mood which would probably be the reason the men keep off the clinic to avoid these attitudes or bitter exchanges. However, 41% of mothers appreciated the work of the providers given the clinic is always heavy because of the free maternity services. They said they were generally kind and very good.

4.5.2 Antenal clinic's environment and its influence on male participation

When asked their opinion on the antenatal clinic's set-up, 47% of the women who responded said that the clinic was clean and in perfect condition whereas, the rest gave a few issues which included congestion in the clinic citing that they could not fit in together with their spouses which resulted to men standing throughout the clinic session because of the shortage of seats. This facilitated poor male participation because the men get bored in the process and end up leaving unattended. 2% of the mothers also felt the clinic was quite slow with very long queues in every service being provided ending up disoganised. This puts off the men since most of them just get few hours off petrmission from their employers to attend the clinic which results to a whole day's agenda. This is further demonstrated in Table 4.8 below.

Table 4.8

Opinion on ANC environment	Frequency	% of Respondents
Small space/congested	16	8.0
Less benches/seats	22	11.0
Few male staff	8	4.0
Delay in clinic/long queues / slow/long	25	12.5
Perfect/fine/ok	51	25.5
Clean	10	5.0
Organized	7	3.5
Mother going on without being attended	13	6.5
Disorganized	17	8.5
Concerned about clients	11	5.5
Wanting services	20	10.0
Total	**200**	**100.0**

4.5.3 Issues that make men not attend clinic

The Table 4.9 below illustrated issues and other reasons which emanated from the ANC

Table 4.9

Issues that make men not attend clinic	Frequency	% of Respondents
Fear of pregnant women/shy	6	3.0
Fear of HIV test	18	9.0
Congestion/not enough space	12	6.0
Clinic is for women	9	4.5
Rude staff	10	5.0
Financial constraints	7	3.5
Selfishness	4	2.0
Busy/work elsewhere	39	19.5
Long queues	70	35.0
High numbers of female staffs	20	10.0
Not answered	5	2.5
Total	**200**	**100.0**

Three percent of the women said that men are uncomfortable with pregnant women and are shy so they did not want to be around them and more so, in a place with so many of them. This was evidenced also where 15% mothers said that their men often complain of so much of the femininity in the clinic where men's lavatories are also absent. This forces the few men who participate in the clinic to go seek for washrooms from other clinics. This has therefore been a contributor to men avoiding the clinic. 9% of respondents reported that fear of HIV test outcomes is also a factor as men want to test by proxy, where they assume that whatever HIV status their wives hold reflects to theirs too. Busy schedules, congestion/insufficient space, rude staff, financial constraints and selfishness are other factors that were cited as making the men not come to the clinic.

4.5.4 Suggestions to improve male participation

When asked to give suggestions on how to improve male participation, 10.5% of the women said that there was need to educate men on the importance of antenatal care through media and mobilization, since many were too busy wtith their schedules (34%) and others did not want to accompany their wives because they were ashamed of them or did not want to be associated with the pregnancy. This was related to a view given by 10% women that men also did not accompany their ladies since the clinic is a women's affair and so feminine for them. To the health workers, they suggested that they improve on their public relation with the clients, and their mumbers increased to avoid mothers being sent home unattended or the long queues which consumed so much time in the clinic. For men to increase in the clinic, it was also suggested by majority (26%) of the women for the clinic to consider a lounge for men with seats and entertainment to keep them busy as they waited to be called in for the necessary services they are required for.

4.5.5 Strategies to get more men involved in the antenatal care

Prioritising the couple in the antenatal clinics was cited as the best way forward to increasing the number of men. 25% of the women said that there was need for making policies in the thecountry which makes it mandatory for all expectant mothers to attend the free maternal health care services accompanied by their spouseswith intensive awareness creation round the country on the importance of male participation in reproductive health through media and campaigns. There was a suggestion by 5% to use invitation letters, general public relation to the clients and quick services to avoid delaying men from going back to work. Contacting men through their mobile was also suggested to give a personal invitation.

4.6 Clients' level of awareness on the services offered in the antenatal clinic

4.6.1 Awareness of the services offered in the antenatal clinic

There are several services offered at the antenatal care. Not all women were able to outline them. The most commonly known service was HIV counseling and testing (49%). This was perhaps because no mother can be attended to without having gone through this service. This is emphasised by the fact that the couple present in the clinic are given first priority so that men can go back to work if they are around for few hours only. Observations which include urinalysis, blood pressure and the weight were cited by 35.5% of the women while 23.5% and 20% mentioned palpation and blood tests respectively. Services like tetanus injections were not quite known to mothers yet they all must have one during their 28th gestation. So, the researcher concluded that the mothers are ignorant even though they are given health talks everyday. The Table 4.10 below showed men's responses on their knowledge on rhe services offered at ANC

Table 4.10

Services offered at ANC	Frequency	% of Respondents
Counseling and testing for HIV	9	43.00
Observation	3	14.25
Blood tests	2	9.50
T.T injection/immunization	2	9.50
Palpation/screening/consultation	5	23.75
Total	**21**	**100.00**

The resonses were from the 21 men who participated where the most known servicewais counseling and testing by 43%. 23% of them recognized the consultations by senior doctors since they joined their spouses during the palpations. Therefore, the researcher concluded that when the men are involved, they are well conversant with the services offered, get more information about the partner's pregnancy and also return in the next appointment.

4.6.2 Awareness on the Modes of HIV transmission

Three quarters of the women (74.5%) mentioned unprotected sex with someone whos is infected with HIV virus as one of the modes of transmission. This was also echoed in the men's report where 33% cited this mode as shown in Table 4.11 below. Other ways of transmission cited by the women include sharing of sharp objects (38.5%), blood transfusion (33%) and

MTCT (23%). 75% of the mothers said that having many sexual partners was also a contributing factor. The men (19%) are also mindful of mother to child transmission and blood transfusion(19%) as the well known transmission routes.Generally, the respondents seemed to be quite informed about these modes perhaps due to vigorous media campaigns.

Table 4.11

Ways one can acquire HIV	Frequency	% of Respondents
Sex	7	33.3
MTCT	4	19.0
Accidents	2	9.6
Sharing sharp objects	3	14.3
Blood transfusion	4	19.0
Fluids on open wounds	1	4.8
Total	**21**	**100**

4.6.3 Male attendance and HIV testing

Majority (38.5%) of the mothers had attended clinic 4 or more times. About a half (48.5%) had been accompanied by their partners for at least 1 ANC visit. The partners had attended once (58.8%), two (25.8%) and three or more (13.4%).Most of the mothers (98%) had been tested for HIV previously and 72.5% had been tested with the partner. 32% of mothers who had never been tested with their partners said men did not come to the clinic because they were too busy in their work places while some men worked far from home.

4.6.4 Awareness of family planning methods

Majority (64%) of the women defined family planning correctly and 76% thought FP methods are important to use. Spontaneous vaginal delivery (SVD) was the most preferred mode of delivery by 82.5% of the women. The reasons given for preference of specific method were the perception that it is the best (26.5%), safe (26%) and ease of healing (17.5%). Table 4.12 below illustrated men's definition on family planning. Majority (33%) said it is the general use of birth control techniques where a couple determines the number of children to have (28.6%) and know when to have these children.

From Table 4.12 below, the researcher concluded that since men are also aware of family planning methods, they play a very key role in the family size determination and so should always attend the antenatal care together with their partners so that in future proper planning and well informed decisions are made to enhance good communication between them.

Table 4.12

What is family planning	Frequency	% of Respondents
Spacing children	3	14.3
Determining number of kids	6	28.6
Use of birth control techniques	7	33.3
Determining when to have children	4	19.0
Having a healthy family	1	4.8
Total	**21**	**100.0**

4.6.5 Reasons why mothers have not tested together with their spouses

Thirty eight per cent mothers gave their reasons for not testing together as that their partners were so busy with very tight schedules while others worked far from home and only being available during the weekends. 17% of the respondents reiterated that their partners did not accompany them for testing because their wives had been tested and therefore saw no need to while 14% said the men fear the HIV test outcomes. The researcher concluded that there was need to sensitize the men and community in general on the issue of discordancy where one partner is HIV positive and the other negative, and so testing by proxy may only mean high sero-conversion rates.

Table 4.13

Reasons for testing with partner	Frequency	% of Respondents
Wedding	23	11.5
To know our status	65	32.5
Asked to test in clinic	55	27.5
To have sex/avoid condom/be truthful	29	14.5
We care/love each other	12	6.0
Sickness/admission	16	8.0
Total	**200**	**100.0**

Thirty three per cent of the mothers reported to have tested together with their partners to know their HIV status before indulging in sexual intercourse as shown in the above Table 4.13. Others (27.5%) tested because it was a requirement in the clinic because of the unborn child whereas 11.5% was for the wedding where in most cases HIV test is mandatory before taking

the vows as shown in the above table. 14% thought it was good to test so that they can now stick to one partner faithfully.

4.6.6 Importance of partner to accompany the mother to the antenatal clinic

Men's responses on the Importance of accompanying thier partner to antenatal clinic were as presented in the Table 4.14 below.

Table 4.14

Importance of accompanying partner to ANC	Frequency	% of Respondents
Get information about/ progress pregnancy	6	28.5
Improve partner communication	2	9.5
Men to be part of pregnancy/responsibility/support	8	38.0
Testing for HIV/knowing your status	5	24.0
Total	**21**	**100.0**

Twenty eight per cent of the men said the importance was to know the progress of the pregnancy whereas 24% viewed counseling and testing as a requirement. Men (38%) seemed to value their partners and so felt the need to take up pregnancy care of the unborn and the emotions of the mother as their responsibility. Others said that when partners are involved, theirs improvement in their communication and general well-being of their relationship.

4.7 Discussions of the Findings

The study sought to assess the socio-cultural factors influencing male participation and the findings indicated that the level of education is crucial in the uptake of the antenatal services. Most particiipants had secondary and tertiary levels of ecucation which indicated good understanding of few services provided if not all. The participants had the cultural mentality that antenatal clinics are women's places and men needed not interfere. This finding is in agreement with Byamugisha (2010), who riterates that men frequently perceive ANC services to be designed and reserved for women, thus are embarrassed to find themselves in such "female" places.Some men believe it is not good to follow your wife to the antenatal clinic even though she exposed her privacy to you at home and that male participation in ANC services is superfluous and that ANC is "a woman's responsibility". Men above 30 yrs were the majority. Some men were employed whereas others were in their own businesses which is evidenced in the findings that they are quite busy making ends meet.

Fron the findings, most of the respondents earned below kshs. 30,000 and this could probably be the reason most men do not come to the clinic so as to avoid using so much money in a day. This was also indicated by majority of women who are unemp;oyed who may be depending fully on their husbands income. In comparison to the literature, a previous qualitative studies study conducted in western Kenya by Reece found that the distance that the male partners have to travel to the clinics for participating in the education, blood tests and counseling, the costs of the transport to the clinics and the amount of time per appointment at the clinic were identified as barriers to male involvement. Access or logistical challenges on the part of men prevented them from participating in ANC. Men talked about their perceived principal responsibilities as providers. Thus, time spent at clinics and away from work or other income generating activities was clearly perceived as a barrier to their participation in ANC program distance, the cost of transport and the clinic operation hours were also mentioned with some frequency (Reece et al. 2010).

The findings from the health services questions were intense. Mothers felt the health care providers were rude and harsh and in some cases ignored the clients. However, there are those who appreciated the fact that the clinic was quite heavy and that the health care providers tried a great deal to remain friendly and helpful despite the burn out. The findings established that there was dominance of the female staff in the clinic which should be improved if it is to encourage the men to cone to the clinic. The main complaint was the congestion in the clinic which made men feel out of place and the long queues which wasted so much time in the clinic.The above finding concurs with the previous studies where Byamugisha et.al (2010), reported that harsh, critical language directed at Ugandan women from skilled health professionals was a barrier to male participation. Harsh treatment of men by health providers discouraged them from returning or participating in antenatal activities. Furthermore, some providers did not allow men access to clinic settings. Men mentioned the negative attitudes of staff members: "Staff members' lack of common courtesy, their "rough handling" of pregnant women and health-care workers not allowing men to enter the antenatal clinic with their partners".

On the question of awareness, it was quite encouraging to know that majority of the clients were keen on the services they receive and they knew where and when they are offered. Almost all said HIV counselling and testing was a key service in which their partners were also invited to accompany them and be tested together. Some participants mentioned the tetanus jab and the family planning methods which they preferred. This showed the health providers needed to

intensify their health talks in the clinic to sensitize and inform all accordingly. Studies have shown that men who are educated about reproductive health issues are more likely to support their partners in contraceptive use, use contraception themselves, and demonstrate greater responsibility for their children (Grady et al., 1996). More importantly, women express great interest in wanting their partners to be involved in joint reproductive health decision-making. For example, a study in Ecuador surprisingly showed that 89% of women wanted their partner to accompany them on their next family planning visit and 94% would have liked their partner to be present during their family planning session (Roy & de Vargas Pinto, 1999; Mehta, 2002).

The researcher therefore concludes that all the factors under investigation are in deed real and influences male participation in the antenatal clinic and a call for intense mobilisaton and sensitization of the importance of male participation to the public, the health providers, the government and the health policy advocates.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the study findings, conclusion of the study and recommendations drawn from the findings the study. The purpose of the study was to investigate the factors influencing male participation in antenatal care in Kenya, a case of Kenyatta National Hospital. This was to help define the importance of the male participation in the reproductive health care and identify any gaps to be filled.

5.2 Summary of findings

Table 5.1: Summary of Findings

Objectives	Main findings
To assess how the socio-cultural factors influence male involvement	The study findings established that majority of the respondents had university/college and secondary education. Very few indicated primary education. The partici[ants cited the ANC as the women's affair and were mostly above 30 yrs of age. Education and age influenced participation of men in the clinic.
To evaluate the economic factors affecting male involvement	The findings showed the level of income of most of the respondents as ranging below kshs.30,000 and the men quite busy in their work places with some in unreliable casual jobs. Thus, coming to the clinic being a waste of time for men and not a priority and the variable affecting male participation.
To explore how the health services influence male involvement	The health providers were found to use harsh language, the clinic very small, congested, having few seats and dorminated by female staffs. The men felt unwanted so the providers should increase furniture for clients and set a specific place for the men to sit as they await the appropriate service in interest.
To assess the clients' level of awareness on the services offered in the antenatal clinic	The study observed that the clients were conversant with few services offered in the clinic like counseling and testing. Therefore, there is need for the health providers to give intensive heath talks and sensitize clients on all the services they should receive in the clinic before delivery

5.3 Conclusions

The conclusions of this study are based on the assumptions that the respondents' responses can be generalized. The conclusion is that socio-cultural issues affect male participation in tbe antenatal clinic. Both men and women are barriers to male participation in antenatal care. They need to keep off the belief that reprodcuctive care a woman's affair and that association with the pregnant wife is unmanly. The study concludes that there is little or no information being given to the public to enhance their knowledge on their general health

The employers are not giving the men their paternal duty to attend the antenatal clinic when required to. Some due to the nature of their jobs may miss the day's pay or allowances and therefore forego the doctor's appointment. Some employers do not motivate their wokers with an insurance cover so that the men do not feel financially pressed when needed to accompany their partners in the clinic. The researcher also concludes that the men generally do not see the need to go to the clinic hence many excuses. Thus need to sensitize the public.

The study concludes that many health services keep men off the clinic. The staffs are few making them have burn-out and hence the arrogant and harsh language use as reported by the clients. This calls for more addition of personnels who will help the services run fast avoiding taking so much time in the clinic. The health facilities have very few male personnels and so a need to be gender sensitive while employing as they could be a motivator to the men. Space need be created because men stand for hours awaiting their partners to be served till the end

The health care providers have not given enough talks to do with services offered and thus need for more refresher courses to the staffs and frequent health sensitization to the clients. The staff are overworked especially with the free maternatl health care and do not have time to engage clients fully thus being labelled ignorant and arrogant to staffs.

5.4 Recommendations

The government could pass laws compelling fathers to be fully responsible for their unborn children by participating in the antenatal clinic services. This could also help the employers be flexible by releasing the men from their tight schedules

Kenyatta National Hospital being a referral institution should employ more human resource personnels to the antenatal clinic given the maternity services are free thus high ratios of

expectant mothers to health providers. More so, they should consider gender balance to avoid dorminance of one gender over the other.

The health providers need be trained on public relations and continuous refresher courses to have a good workers' relationship and also know how to handle clients in their different nature. The staff also need supervision counselling to vent out their burning issues

An intense capacity building or mobilisation campaign is important in the clinic and the country to educate people on the importance of their health. The clients need be equipped with all information pertaing birth preparedness, labor signs, modes of delivery and family planning methods etc.

5.5 Suggested areas for further research

This study has reviewed factors influencing male participation in the antenatal clinic, a case of Kenyatta National Hospital. These factors are not exhaustive and therefore the researcher recommends that further study should be carried out to establish more factors influencing male participation in other government and private hospitals to find out if they differ. The researcher also recommends that further study of the same factors should be done using different methodologies to check whether the same findings will be valild.

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APPENDICES

APPENDIX 1: LETTER OF TRANSMITTAL

Gathuto Mary Nungari.

P O. Box 29707 – 00202,

Nairobi.

Reg.No:L50/70541/2011

Tel: 0721513718

Email; marynungari@yahoo.com

Dear respondents,

I am a student at the University of Nairobi undertaking a master's degree in Project Planning and Management. I am working on a research project on low male participation in the Antenatal Clinics in Kenya.

The purpose of this letter is to request you to participate in this study and fill in the questionnaire. All responses will be treated confidentially. Kindly answer all the questions to the best of your knowledge in order to help me fulfill the objectives of this significant study.

This will help the country in improving and eliminating mother to child transmission of HIV/AIDS, sensitization and awareness towards couple testing.

Your acceptance and participation will be highly appreciated.

Thank you.

Yours faithfully

Mary NungariGathuto

RESEACHER

APPENDIX II: QUESTIONNAIRE FOR MEN

THIS QUESTIONNAIRE WILL HELP THE RESEARCHER TO UNDERSTAND THE FACTORS INFLUENCING MALE INVOLVEMENT IN THE ANTENATAL CLINIC. THE INFORMATION YOU GIVE WILL BE HIGHLY CONFIDENTIAL, SO PLEASE ANSWER ALL THE QUESTIONS APPROPRIATELY AND SINCERELY.

Use a Tick ☑ where appropriate

1. Age: .....
2. Residence: .....
3. Highest level of education: .....
4. Are you employed? Yes ☐ No ☐
5. If yes, what is your salary range in Kshs?
   Over 80,001 ☐ 60,001 – 80,000 ☐ 30,001 – 60,000 ☐
   15,001 – 30,000 ☐ Below 15,000 ☐
6. If not employed, what do you do for a living? .....
7. Marital status: Married ☐
   In a relationship ☐ Specify) .....
8. How many wives do you have? .....
9. How long have you been married? .....
10. Other than your wife(s), do you have other sexual partners?Yes ☐ ☐
11. If yes, how many? .....
12. If yes, what pushed you to going outside your marriage?
    a) my wife does not satisfy my sexual urges ☐
    b) just to satisfy my ego that i am a man enough ☐
    c) Peer pressure ☐
    d) I am rich. I woo women with my money ☐
    e) Other reason, (Specify) .....
13. Do you have children? Yes ☐ No ☐
14. If yes, how many? .....
15. How many times have you attended your child(ren) immunization? .....
16. How many times have you attended antenatal clinic? .....
17. Do you know about antenatal care? Yes ☐ No ☐
18. What services do you know that are offered in the antenatal clinic?

19. What are some of the ways in which one can acquire the HIV virus?

20. Have you been tested for HIV before? Yes ☐ No ☐

21. Have you been tested with your wife(s)/girlfriend(s) before? Yes ☐ No ☐

22. If yes, **when** and **what** were the reasons for testing together?

23. If no, why have you not tested together?

24. What do you think is the importance of accompanying your partner to the ANC?

25. What is your opinion on the antenatal clinic setting/environment?

26. What is family planning?

27. What method do you use (if any)?

28. Is it good to use family planning methods? Please explain briefly.

29. What method of delivery do you prefer for your partner?

30. Why do you prefer the above method?

31. What would you say about the attitude of health care providers (staff)to the clients?

32. What do you think are the factors in the antenatal clinic that would make men not to accompany their partners?

33. Please give exhaustively other reasons why you think men avoid the antenatal clinics

34. Give suggestions on how to make the clinic environment more conducive and welcoming to the men.

35. What strategies can we use to encourage other men to accompany their wives/partners to the clinic without feeling coerced?

36. Does your employer/employment support your clinic attendance by giving you permission when necessary? Explain briefly.

37. Give a parting shot comment.

THANK YOU

APPENDIX III: QUESTIONNAIRE FOR MOTHERS

THIS QUESTIONNAIRE WILL HELP THE RESEARCHER TO UNDERSTAND THE FACTORS INFLUENCING MALE INVOVLVEMENT IN THE ANTENATAL CLINIC. THE INFORMATION YOU GIVE WILL BE HIGHLY CONFIDENTIAL SO PLEASE ANSWER ALL THE QUESTIONS APPROPRIATELY AND SINCERELY.

Use a Tick ☑ to select the appropriate answer

1. Age .....
2. Marital status
   Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐
3. If you are **single**, is it your choice?Explain briefly.
   .....
   .....
4. Where do you stay? .....
5. How many children do you have? .....
6. What is your highest education level?
   University ☐ College ☐ Secondary School ☐ Primary School ☐
   Primary School Dropout ☐
7. If **married**, what is your husband's highest education level?
   University ☐ College ☐ Secondary School ☐ Primary School ☐
   Primary School Dropout ☐
8. Other than your husband, do you have other sexual partners?Yes ☐ No ☐
9. If yes, how many? .....
10. If yes, what pushed you to going outside your marriage?
    .....
    .....
    .....

EMPLOYMENT

11. Are you employed?Yes ☐ No ☐
12. If yes, what scale does your salary range in Kshs?
    Over 80,001 ☐ 60,001 – 80,000 ☐ 30,001 – 60,000 ☐
    15,001 – 30,000 ☐ Below 15,000 ☐
13. If no, what do you do for a living? .....
    House wife ☐ Other ☐(Specify) .....
14. What is your husband's occupation?
    ☐ ☐ ☐

Employed Businessman Unemployed

15. If employed, what scale does his salary range in Kshs?

Over 80,001 ☐ 60,001 – 80,000 ☐ 30,001 – 60,000 ☐

15,001 – 30,000 ☐ Below 15,000 ☐

CLINICAL MATTERS

16. How many times have you attended the antenatal clinic in KNH? .....

17. Has your husband/partner accompanied you at least ones for the appointment?

Yes ☐ No ☐

18. If yes, how many tineshas he accompamied you? .....

19. If no, why has he not attended the clinic appointment with you?

.....

.....

.....

20. What services do you know that are offered in the antenatal clinic?

....

....

....

21. What are some of the ways in which one can acquire the HIV virus?

....

....

....

22. Have you been tested for HIV before? Yes ☐ No ☐

23. Have you been tested with your husband/partner before? Yes ☐ No ☐

24. If yes, **when** and **what** were the reasons for testing together?

.....

.....

.....

25. If no, why have you not tested together?

.....

.....

.....

26. Why do you think it is importance foryour partner to accompany youto the ANC?

.....

.....

.....

27. What is family planning? .....

28. Which family planning method do you use? .....

29. Is it good to use family planning methods?

30. Whichmethod of delivery do you prefer? _____
31. Why do you prefer that metnod? _____
32. What would you say about the attitude of the health care providers to the clients?

33. What is your opinion on the antenatal clinic setting/environment?

34. What do you think are the issues in the antenatal clinic that would make men not to accompany their partners?

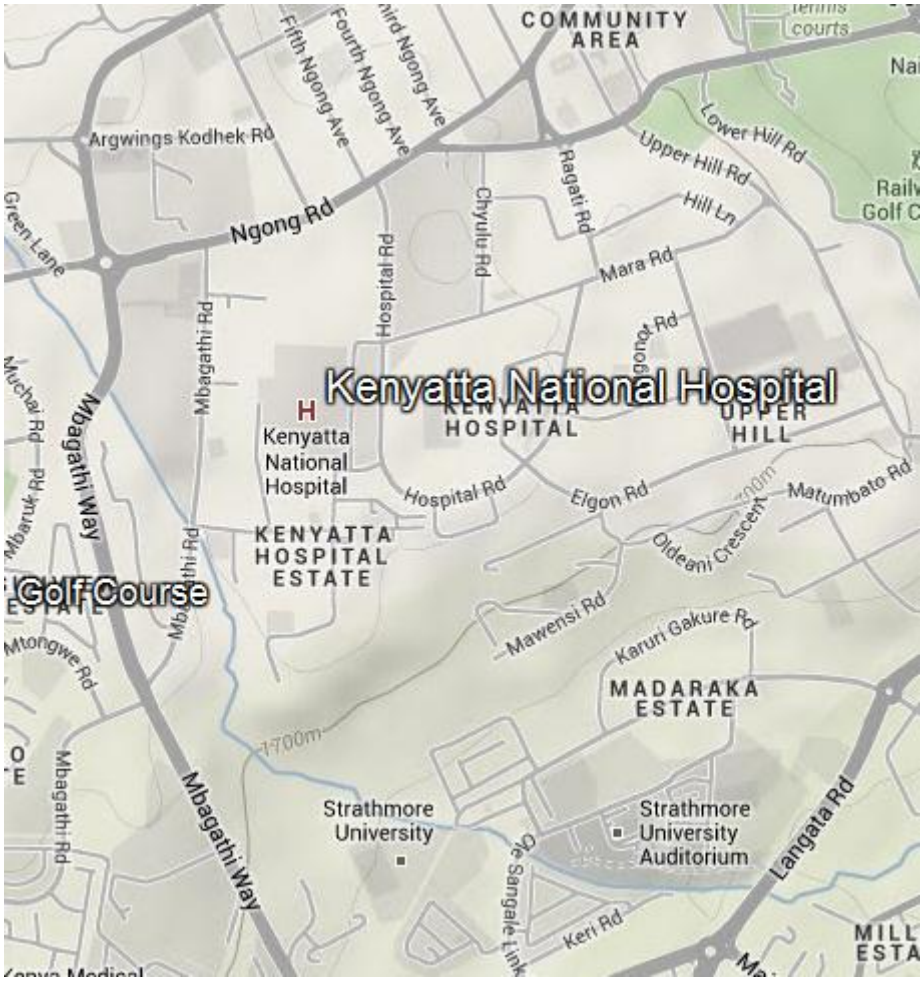
35. What other reasons do you think men give for not attending the antenatal clinic?

36. What would you suggest to improve the clinic environment to be conducive for the men?

37. What strategies do you think we can use to get your spouse or more men involved in the antenatal clinic?

THANK YOU

APPENDIX VI: MAP OF KENYATTA NATIONAL HOSPITAL



A map of Kenyatta National Hospital, source; Mapcarta.htm