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# Role of Men in Birth Preparedness: A Qualitative Study of Women Attending Antenatal Clinics in Migori County, Kenya

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**ABSTRACT**

***Background & aim:*** Male involvement is evidently an effective strategy for enhancing maternal health outcomes. Although childbirth has traditionally targeted women, the key roles of men in decision-making and financial support cannot be ignored. This study aimed to analyze women's perception of men in birth preparedness in Migori County, Kenya.

***Methods:*** This qualitative study was conducted on 32 pregnant women attending selected public health facilities in Migori County from January to March, 2016, using conventional content analysis. The study population was selected through purposive sampling technique. Data collection was performed by means of focus group discussions (FGD) organized in four high-volume health facilities. Discussions were recorded based on FGD guidelines. Subsequently, the recorded data were transcribed and reduced into themes. The thematic analysis of the results was reported in the form of narration.

***Results:*** The analysis of the data led to the identification of some important themes, including decision making for labor and delivery, financial support, birth companionship, house caretaking in the absence of women, and non-involvement of men in birth preparedness.

***Conclusion:*** Men play a key role in birth preparedness in terms of economic and emotional support. Although some cultures prohibit men from participating in the process of birth preparedness, there is a need to educate men in this regard. It is recommended to make more efforts to encourage men's participation through community education, which can effectively modify prohibitive cultural practices.

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## Introduction

Pregnancy and childbirth complications can never be predicted; therefore, birth preparedness is a strategy to ensure safety for both the mother and her unborn child (1). Death of a mother or her neonate during pregnancy or childbirth is devastating (2). Every year, 287,000 women die as a result of pregnancy and childbirth complications all over the world (3), mostly in the developing countries (4). In Kenya, the maternal mortality ratio is 362/100000 live births (5). Migori County in Nyanza Province, Kenya, has poor maternal health indicators with the maternal mortality rate of 673/100000 live births in 2014 (6), which is way above the national average. The leading cause of maternal mortality is sepsis, followed by haemorrhage (7). Adequate preparation can help the early identification and treatment of the complications.

The World Health Organization introduced birth preparedness strategy through antenatal care (ANC) model. The strategy is aimed at preventing the obstetric delays and promoting the utilization of skilled birth attendance, which in fact, prevent childbirth complications (8).

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Birth preparedness involves the recognition of the signs of danger, plan for a skilled attendant during childbirth, identification of health facilities in case of emergency or labor, plan for means of transportation, allocation of enough money to emergency or delivery, and plan for house caretaking in the absence of mother for delivery (9). In this regard, men can play a significant role in the preparation for birth (10).

Male involvement refers to the support and care provided by the partner to the pregnant woman with the aim of achieving a good pregnancy outcome. In order to achieve success in maternal health, the participation of men is vital (5). In the African societies, pregnancy and childbirth are largely undertaken by women, and men are involved in this process less than women. Culturally, in some communities, it is unacceptable for a man to witness a women giving birth to a child, and the woman does not approve the physical presence of the men (6). In most of the cases, the role of the father is to escort the mother to the health facility and picks the mother and neonate up after delivery (11).

Evidence indicates that men involvement leads to better reproductive health outcomes (12). The involvement of men in childbirth is rare in many parts of the world (13, 14). Men involvement can lead to preparedness, as well as avoidance of obstetric delays, which may arise due to the lack of preparation at the time of emergencies (15). Couples can enjoy the benefits of better outcomes when men are involved in both prenatal and postnatal periods rather than accompanying their spouse only during delivery (16). Men in many patriarchal societies are decision makers in family and societal matters. In addition, they are mostly family breadwinners, which indicates their value as a resource provider during pregnancy and childbirth (17). Men involvement in birth plan facilitates the elimination of cultural barriers by informing them about their roles; therefore, misconceptions are avoided. This also enables them to share their decisions on the birth plan with their partners (8).

A number of factors, including education level and occupation, can affect male involvement in pregnancy and childbirth (17, 18). Some women choose to confide their pregnancy to their mothers, mothers-in-law, sisters, or female friends before disclosing it to their partners (19). This affects the preparation for childbirth since the informed partners may not usually be in a position to make decisions for her. The ANC clinics operate within the office hours, especially in the public health facilities, which makes it difficult for the employed men to find time to accompany their spouses (13). Therefore, men do not feel to be a part of the health system when they do not accompany their partners for antenatal care (19). In some health centres, men are not allowed to enter the examination room, and they have to wait for their partners in the waiting room. This makes them feel demotivated, which leads to unwillingness to join their partners in the subsequent visits (10). Men act as gatekeepers to women's health; therefore, it is important to assess their involvement in birth preparedness. This study was conducted to explore women's perception of men's role in birth preparedness in Migori.

### *Public health significance*

Maternal mortality is an issue of global public health concern. No woman should die while giving birth, and every newborn has the right to live. One way of preventing maternal and neonatal mortality is to encourage men to use their capacity as decision makers and financial supporters. Men in most of the communities are the gatekeepers with high self-esteem. Culturally, they have an influence on maternal health despite their low level of involvement. When men are aware of birth preparedness, they can have a positive influence on maternal and neonatal health. There is a need to recognize the role of men in society and manage their involvement in the health policies and systems.

## Materials and Methods

This qualitative research was conducted on women of reproductive age, referring to four selected public health facilities in Migori County using conventional content analysis. Data were collected through focus group discussions (FGDs) from January to March, 2016. The FGD groups were held in Migori County Hospital, Isebania Sub-County Hospital, Godkwer Health Centre, and Arombe Dispensary, which are high-

volume health facilities, located in the urban and rural areas. The participants were selected by purposive sampling technique. The exclusion criteria were age, parity, and gestation. The paradigm of inquiry adopted in the study was interpretivism since the information obtained was subjective and the validity of truth mainly depended on the context.

The process of recruiting the participants began as soon as the women assembled in ANC clinics. To this end, the subjects were asked to pick random papers, labeled as 'Yes' and 'No'. Those who picked 'Yes' participated in the FGD. In each FGD, eight women were interviewed. Four interviews were carried out, with a total of 32 participants taking part in the FGDs. There was only one respondent who was unwilling to have her voice recorded; therefore, she was excluded from the study. After informing the participants about the study objectives, informed consent was obtained regarding the recording of the data. Furthermore, the subjects were assured about the confidentiality of their data.

Discussion sessions were held by the principal researcher using an FGD guide. Prompts were given to the participants for the more clarification and illumination of responses. Each interview took approximately 30 min. The researchers continued interviewing the participants until data saturation. All interviews were recorded and transcribed verbatim. Subsequently, the interviews and field notes were analysed to derive the main themes. In order to ensure trustworthiness, the FGD guide was pre-tested. In addition, the participants were clearly informed of the research objectives, and honest answers were encouraged.

After reading the interview transcriptions precisely for several times, they were analysed through the open coding system to extract the primary concepts. Data were sequentially coded by two coders to ensure that the information was not distorted. The codes were sorted manually to enable the analysis of the created pattern. During the coding process, ideas with similar meaning were used to form categories. In the next stage, the data were labeled in each category and subcategory until there was no new theme. This resulted in the extraction of five themes from the data. Thematic areas were created, and content analysis was performed. The data were reported in form of narration.

### *Ethical considerations*

Ethical approval was obtained from the University of Nairobi/Kenyatta National Hospital Ethical Review Committee.

## Results

A total of 32 pregnant women participated in the FGDs. The emerging themes during the FGD regarding the role of men in birth preparedness were decision making for labor and delivery, provision of financial support, birth companionship, house caretaking in the absence of woman, and non-involvement of men in birth preparedness.

### *Socio-demographic characteristics of the participants*

The age range of the respondents was 16-33 years with a majority (64.5%) ranging within 18- 23 years. Half of them (51.1%) had the education level of standard eight. In terms of the occupational status, 67.7%, 25.8%, and 6.5% of the participants were housewives, small-scale businesswomen, and students, respectively. Most of the respondents were of low parity, primigravida (25.8%), para 1 (29%), and para 2 (22.6%) with no abortion. The highest parity was para 6+0 (3.2%). Most of the respondents (90.3%) were referring to ANC clinics for their first or second time. The gestational age at the time of the study was within the range of 12-39 weeks; however, the majority of them were in their second trimester (45.2%). Only 3.2% of the respondents were in the first trimester (Table 1).

### *Decision making for labor and delivery*

According to the respondents, men played a very vital role in making decisions about the place of giving birth or household needs. Some of them even decided on whether their spouse would deliver in the main hospital or with the assistance of the traditional birth attendant. The men also decided how the household finances would be spent and when to buy clothes for the neonate.

*"When time of labor comes, my husband will decide where he will take me because our home is*

*far from the County hospital." (Respondent 11)*

*"My husband prefers me to deliver with the assistance of traditional birth attendant because they are good." (Respondent 22)*

*"My husband is the one who is working so he is the one who has money. He will decide when to buy the baby clothes and other household needs."*

**Table 1.** Sociodemographic characteristics of the participants

| Participant | Age | Education level | Occupation | Parity | ANC visit No. | Gestation (weeks) | Facility |
|---|---|---|---|---|---|---|---|
| 1 | 19 | Form IV | Business | 0+0 | 1 | 12 | Migori CRH |
| 2 | 18 | Std 8 | Housewife | 1+0 | 1 | 20 | Migori CRH |
| | 23 | Std 8 | Housewife | 1+0 | 1 | 14 | Migori CRH |
| | 20 | Std 6 | Housewife | 3+0 | 1 | 15 | Migori CRH |
| | 20 | Std 8 | Housewife | 2+0 | 1 | 20 | Migori CRH |
| | 18 | Form II | Housewife | 0+0 | 1 | 22 | Migori CRH |
| | 16 | Std 7 | Student | 0+0 | 1 | 16 | Migori CRH |
| | 22 | Form IV | Business | 1+0 | 2 | 24 | Migori CRH |
| | 17 | Std 8 | Housewife | 0+0 | 2 | 32 | Arombe |
| | 33 | Std 8 | Housewife | 1+0 | 2 | 19 | Arombe |
| | 28 | Std 3 | Housewife | 4+0 | 3 | 32 | Arombe |
| | 33 | Std 7 | Housewife | 2+0 | 4 | 38 | Arombe |
| | 28 | Std 7 | Housewife | 1+0 | 2 | 34 | Arombe |
| | 24 | Std 8 | Housewife | 3+0 | 1 | 30 | Arombe |
| | 23 | Std 8 | Housewife | 2+0 | 2 | 28 | Arombe |
| | 19 | Std 6 | Housewife | 1+0 | 1 | 24 | Arombe |
| | 20 | Std 8 | Housewife | 1+0 | 3 | 33 | Godkwer |
| | 27 | Std 8 | Tailor | 6+0 | 1 | 39 | Godkwer |
| | 25 | Std 8 | Housewife | 5+0 | 2 | 28 | Godkwer |
| | 23 | Std 7 | Business | 3+0 | 2 | 26 | Godkwer |
| | 20 | Std 6 | Business | 2+0 | 2 | 30 | Godkwer |
| | 19 | Std 8 | Housewife | 1+0 | 1 | 32 | Godkwer |
| | 20 | Std 7 | Housewife | 2+0 | 2 | 28 | Godkwer |
| | 22 | Std 8 | Housewife | 3+0 | 2 | 24 | Godkwer |
| | 22 | Std 8 | Tailor | 0+0 | 1 | 35 | Isebania |
| | 26 | Std 8 | Farmer | 2+0 | 2 | 32 | Isebania |
| | 19 | Std 7 | Housewife | 0+0 | 1 | 31 | Isebania |
| | 23 | Std 6 | Housewife | 2+0 | 2 | 34 | Isebania |
| | 18 | Std 5 | Farmer | 0+0 | 1 | 35 | Isebania |
| | 17 | Std 7 | Student | 0+0 | 1 | 33 | Isebania |
| | 20 | Std 8 | Housewife | 1+0 | 2 | 32 | Isebania |
| | 19 | Std 8 | Housewife | 1+0 | 2 | 28 | Isebania |

ANC: antenatal care

*(Respondent 29)*

*"If my husband will have money, he will give me so that I buy what I need early before delivery." (Respondent 16)*

*"When I will be going to hospital, my husband is the one who will decide who will remain at home to take care of the young children." (Respondent 14)*

### *Financial support*

According to the respondents, men were almost involved in birth preparedness through providing the needed money during labor or escorting the woman during labor to hospital. However, some respondents said men did not do anything with regard to the preparation as this was the role of the woman.

*"The men provide money when I come to hospital or clinic to deliver." (Respondent 7)*

*"My husband will provide the money to be used for transport and pay the hospital charges." (Respondent 12)*

*"It is the man's duty to get the money which will be needed to buy clothes for the baby and other household necessities." (Respondent 18)*

*"My business will help me to get money for buying baby clothes and food because my husband is not concerned about this. His role is just to pay school fees for the children." (Respondent 9)*

***Birth companionship***

The men mainly accompanied them to the health facility, but did not stay with them through the labor and delivery since it was not culturally accepted according to the respondents. Other health facilities did not allow men to stay during labor since the labor and delivery rooms were small and were shared with other patients, and the presence of men affected other patient's privacy. Some women chose not to have their spouses escort them to the health facility and their reasons were their preference to be alone, living away from the spouse, or lack of support and willingness from the spouse.

*"My husband will call the boda boda and take me to hospital when labor begins." (Respondent 2)*

*"He will bring me to hospital, but he will not enter the labor room. My companion will be a nurse." (Respondent 5)*

*"It is the duty of my husband to escort me up to hospital, but he will not stay with me there. Once I deliver, he will come and take us back home." (Respondent 23)*

*"In this facility, the nurses do not allow the men to stay in the delivery room because sometimes, there are two women giving birth at the same time, and it is not good for another man to see the nakedness of a woman who is not his wife." (Respondent 10)*

*"My husband works far from home; so, he will only come after I give birth." (Respondent 31)*

*"I will inform my husband about the due date that I will deliver then he will be around home so that when labor begins, he will take me to the hospital." (Respondent 27)*

*"I will go alone to the hospital because I don't want my husband to see me delivering. This is not my first child." (Respondent 25)*

*"Even if I wanted to go with my husband to the health facility, he will refuse because culturally, delivery belongs to women. So, I will go with my mother-in-law." (Respondent 13)*

***House caretaking***

Regarding the delivery time, most of the respondents opted for their spouses, mother-in-law, or co-wife to take care of their home in their absence. A few of the women who had older children reported that their children would take care of home while they will be away. These are the responses from the FGD groups with regard to the plan for a caretaker:

*"My husband will take me to hospital, and then he comes back to take care of the children at home." (Respondent 3)*

*"My co-wife or mother-in-law will take care of home when I go to hospital. One of them will take me to hospital and the other one will stay at home." (Respondent 20)*

*"My children are old enough, and they will be able to look after themselves until I come back from hospital." (Respondent 32)*

*"Because I will not go with my husband to the hospital, it is his responsibility to look after home when I go to deliver." (Respondent 6)*

***Why men do not participate in birth preparedness?***

Some of the respondents cited that men did not play any roles in birth preparedness. The men did not act as birth companions as they would not be in the labor ward until the baby is born. They also did not help in housework during pregnancy or even after child birth because of the cultural beliefs. The women got assistance from their co-wives or mother-in-law as it is culturally accepted.

*"The men are not allowed to see where the baby is coming out. So they do not go to the hospital when a woman is going to maternity ward" (Respondent 17)*

*"They do not do anything about childbirth. This is the duty of the woman." (Respondent 19)*

*"The men can't help in the housework because it is culturally unacceptable. The person who will help me is my co-wife." (Respondent 24)*

*"My husband says when his friends find out he is helping me with housework, they will laugh at him. So, he will not accept to do anything in the house. Holding the baby is not acceptable." (Respondent 26)*

## Discussion

The role of men in prenatal and postnatal periods is not clearly defined in many societies due to the fact that childbirth is an event which is largely viewed as women's duty. In the past, men were rarely involved in childbirth since this was culturally accepted as an activity undertaken by women. Based on the evidence,

male involvement in reproductive health matters is very indispensable owing to their role in the community as decision makers and economic supporters (20). Involvement of men in birth preparedness enables the couple to be ready in case of emergency; therefore, the woman can utilize obstetric services.

In many societies, men are the head of the households; therefore, they hold a key position in making household decisions. Men offer a supportive role to the women during prenatal and postnatal periods. Our findings indicated that men were involved in decision making regarding birth preparedness, which was in line with the results of the studies conducted in Nepal (21) and South Africa (22).

Men are mostly breadwinners and have the responsibility of economic support in many societies, more specifically in the developing countries (23). The findings revealed that men were involved in providing money for the birth preparation of their women. This is in agreement with an Indian study which established that men were mainly decision makers and economic power holders (24). In a study conducted in Busia, Kenya, there was a significant relationship between male involvement and utilization of skilled birth attendance (i.e., a practice of birth preparedness) (25). However, these findings are in contrast with those of a study conducted in Nigeria, which revealed that only few men had savings to be prepared for delivery (20).

Having a companion has been found to contribute to the psychological and emotional wellbeing of the woman during labor. The companionship of the partner provides the women with better support and enhances their learning (26). Moreover, they are more likely to utilize skilled birth attendance if their partners accompany them to ANC clinic (27). The findings indicated that men rarely accompanied the women during labor, although they escorted them to the health facility. This finding is in agreement with the results of a study conducted in Rwanda, reporting low men involvement in ANC care (12). Accordingly, Nigerian studies reported that fewer men accompanied their wives during labor (13, 20). This is in sharp contrast with a study conducted in India, in which men accompanied their wives during labor (24). Some women did not want the presence of their partners during labor since it was culturally inappropriate, which is in accordance with the findings of a study carried out in Rwanda (12).

The presence of a caretaker at home makes women less anxious while in hospital. Without a caretaker, the woman is likely to be worried about her home while she is away, especially if she has younger children. In the current study, men acted mainly as house caretakers in the absence of the women, which lends support to the studies performed in Malawi (28) and Ghana (28).

Men have been rarely involved in maternal health issues in many societies. The findings of the present study indicated that in some cases, the men were not involved in birth preparedness at all and could not assist women in household chores or other activities. The findings of several studies were also indicative of low men involvement in birth preparedness (12, 24). Our results also indicated that men were less involved because pregnancy and childbirth were perceived as female duties, which is also supported by a study conducted in Ghana (29). The findings of the current study were limited to the data collected from women's point of view; therefore, men may have a different perspective towards birth preparedness.

## Conclusion

Men are involved in birth preparedness through decision making and economic support. They also escort their partners to the health facilities; however, they may not be present at the time of delivery as a result of cultural practices. Men should be educated and involved more to enhance birth preparedness. Cultural practices which impede male involvement should be reconsidered through community education.

## Authors' contribution

Joyce Cheptum substantially contributed in the conception of the research, data collection, compilation of the document, and data analysis of the study findings. Grace Omoni collaborated in the preparation of the document, data analysis, and revision of the manuscript. Waithira Mirie collaborated in the preparation of the document, data analysis, and revision of the manuscript.

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## Conflicts of interest

The authors declare no conflict of interest.

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