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Male partner Involvement in Maternal Health: An Assessment of Knowledge and Practices among Men in Kuria East Sub-County, Kenya

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ABSTRACT

Male partner involvement (MPI) in Maternal and Child Health (MCH) has been associated with better MCH outcomes worldwide. In view of this, the government of Kenya has initiated various legal and policy measures, as well as implemented and supported the implementation of programmatic interventions to encourage MPI in MCH in various places, including Kuria East sub-county in Migori County- Kenya. This study therefore assessed MPI knowledge and practices among men in Kuria East Sub-County. A sample of 378 main respondents was selected using the systematic random method, after multi-stage clustering. Key informants were purposively selected from healthcare workers and community own resource persons. Data was collected from main informants with the aid of questionnaire and focus group discussions, and from Key informants using interviews. Quantitative data were analyzed by SPSS, using descriptive statistics such as means and percentages, and presented using Tables and graphs. Qualitative data were analyzed thematically and presented in form of narratives. The study showed that male partners have high level of knowledge on involvement in maternal and child healthcare. The study also revealed low MPI practices in the study area attributed to a strong cultural belief. Based on the findings, the study recommends that future MPI interventions should start by targeting culture change, before achieving behavior change.

KEY WORDS

Male Partner Involvement; Maternal Health, Knowledge and Practices; Kuria East; Maternal Health Outcomes

INTRODUCTION

Male partner involvement (MPI) in Maternal and Child Health (MCH) has been associated with better MCH outcomes in Nepal (Sharma, Bhuvan, & Khatri, 2018), Pacific (Davis, Vyankandondera, Luchters, Simon & Holmes, 2016), and Australia (Holmes, Davis & Luchters, 2013; Centre for Social Development, Humanitarian Affairs (United Nations), UNICEF., United Nations Population Fund, United Nations Development Fund for Women, United Nations. Statistical Division, & Inter-parliamentary Union, 2010). Similarly, Chersich, Comrie-Thomson, Davis, Luchters, Portela and Tokhi (2018) indicated that in low and middle income countries, MPI in MCH led to an improvement in infant feeding practices, enhanced uptake of child immunization and care-seeking for childhood illnesses.

A similar trend has been reported in Africa, where MPI in MCH has been associated with reduction of maternal and infant mortality and promotion of child development, as well as optimum maternal and child health in Ghana (Dery, Ganle, Manu & Obeng, 2016), South Africa (Boily, Gregson & Mohlala, 2012), West and Central Africa (Aliyu, Audet, Bussell, Dunlap, Foderingham & Wester, 2014). MPI was also found to improve awareness about obstetric danger signs and enhance institutional delivery in Ethiopia (Tessema, Mihirete, Mengesha, Nigussie & Wondie, 2021). In Uganda, it was reported that MPI significantly improved communication among partners (Muheirwe & Nuhu, 2019) and also led to better antenatal and post-natal attendance (Ekirapa-Kiracho, George, Morgan, Muhumuza & Tetui, 2017; Ediau, Iriso, Machingaidze, Otim, Olwedo, Tumwesigye & Wanyenze, 2013).

In Kenya, MPI in MCH has provided an opportunity to educate men on MCH, which has resulted in favorable attitudes towards access to MCH services, including antenatal care (ANC), skilled deliveries, post natal care (PNC), and use of antiretroviral drugs (ARVs) for prevention of mother to child transmission (PMTCT) (John-Stewart, Kinuthia, Langat, McGrath, Odeny, Pintye, & Singa, 2019; UNICEF, WHO, World Bank Group and the United Nations Population Division, 2019).

In recognition of the benefits of MPI in MCH, the government of Kenya has implemented several legal interventions, including the Employment Act (2012), which grants a two weeks paternal leave with full pay for new fathers; Huffman, Maternal, Infant and Young Child Nutrition (MIYCN), Schofield, (2013), which encourages MPI in MCH. Furthermore, the Kenyan ministry of health has been involved in integration of fatherhood initiatives in MCH by supporting low-income fathers through employment training, father inclusion in family planning services, and expansion of birth data collection to include father information in the healthcare services of spouses and children. Furthermore, the government of Kenya has initiated maternal health education drives, which target both men and women to increase awareness; increase health seeking behaviour among pregnant women; raise awareness on use of family planning (FP) in the postpartum period, and also increase awareness of dual protection for sexually transmitted infections (STIs), as well as increase understanding of the role played by men and

recognition of male partner attendance in ANC, (Bosire, Farquhar, Gatuguta, Igonya, Kagwaini, Kiarie, Odeny, Nduati & Pfeiffer, 2016).

In view of the aforementioned benefits of MPI, and the resultant interventions in Kenya, this study sought to establish the knowledge and practices of male partner involvement in maternal health in Kuria sub-county, Migori County, Kenya.

METHODS

This study was conducted in Kuria-East Sub-County, Migori County, Kenya. The study area was purposively selected because it was established that various awareness campaigns on MPI had been conducted in the region, hence the need to find out if these awareness interventions resulted in improved MPI in MCH. Located on Kenya's border with Tanzania, Kuria East sub-county borders Kilgoris sub-county to the East, Tanzania to the West and Kuria west to the South. It covers a total area of 187.6km^2 with a population of 96,872 (516 persons/km^2).

The target population for this study comprised of 24,257 married men who were the main respondents, as well as key respondents drawn from community leaders and healthcare workers in the study area. The sample size was 378, which was arrived at using Krejcie and Morgan (1970) formula.

Main respondents were selected using three-stage sampling procedure. In the first stage, the study area was clustered into divisions, from which two were purposively selected to capture both urban and rural populations. In the second stage, the selected divisions were clustered into locations, from which 26 were randomly selected. In the final stage, the selected locations were clustered into sub-locations, out of which 13 were purposively selected, taking into account population dynamics. A proportionate quota of the sample was then assigned to each sub-location. From each selected sub-location, data collection sites were carefully identified in consultation with the assistant chiefs and village elders. For each selected data collection site, a sampling frame was drawn with the assistance of village elders, from which respondents were selected using the systematic random sampling method.

The questionnaire was administered by research assistants (RAs), who were first trained on data collection techniques and research ethics. All Key Informant Interviews and focus group discussions (FGDs) were conducted by the principal investigator and senior researchers. Data were collected in strict adherence to all the ethical principles of social research, and analyzed with the statistical package for social sciences (SPSS).

RESULTS

The study established the demographic characteristics of the respondents, which aimed at establishing whether the respondents were a representative sample of the target population for generalization of the study results. The demographic information studied included age, educational attainment and occupation. The findings are presented in Table 1.

Table 1: Respondents' socio-demographic characteristics

Respondents' Demographic Features		F	%
Age Distribution	18-24	39	13.1
	25-29	94	31.7
	30-34	60	20.2
	35-39	47	15.9
	40-44	20	6.7
	45-49	10	3.4
	50-54	17	5.7
	55-59	9	3.0
	TOTAL	**296**	**100**
Level of Educational Attainment	No schooling	40	13.5
	Primary School	121	40.9
	High School	76	25.7
	Tertiary college	50	16.9
	University Degree and Above	9	3.0
	TOTAL	**296**	**100.0**
Occupation	Peasant Farming	187	63.7
	Petty Business	62	20.9
	Small Scale Mining	14	4.7
	Formal employment	6	2.1
	TOTAL	**296**	**100**

The results in Table 1 reveal that approximately two thirds (65.2%) of the respondents were aged between 18 and 34 years. This is an indication that men in the study area marry at an early age, considering that studies in other parts of Kenya have found that more than half of all married men are aged 35 years and above, (Chattopadhyay & Govil, 2021). This could potentially have significant implications on male partner involvement, because various studies aver that younger men are more receptive to the idea of male partner involvement in MCH than their older counterparts. The early marriage age among men could also be related to the fact that a vast majority (80.1%) of the respondents had not gone beyond high school, as shown in Table 1. According to UNESCO (2020), the average age of completion of high school in Kenya is 18-20 years. Furthermore, Kabubo-Mariara, Wambugu and Machio (2017) found that most young men and women in the Nyanza region of Kenya, where the study area is located, enter into marriage soon after completion of basic schooling, implying that those who stop schooling at an earlier age tend to marry at an earlier age. Similarly, Kabubo-Mariara et al. (2017) found an association between the age at which youths stop schooling and the age of marriage.

However, as can be seen in Table 1, the level of educational attainment in the study area is relatively low, compared to that reported in other parts of Migori County, where the study area is located. According to Kabubo-Mariara et al. (2017) the level of educational attainment in Migori County is relatively high, with more than 95% having completed high school, and 81% having obtained a post-secondary school education. The relatively low levels of educational attainment in the study area therefore, could have a bearing on MPI in MCH because according to Levtov, Van der Gaag, Greene, Michael and Barker (2015), male partner's level of education influences their involvement in MCH.

The study also obtained information on the occupation of respondents. Respondents were asked to list the economic activities that they were engaged in, and as can be seen in Table 1, approximately two thirds (63.2%) of the respondents listed peasant farming as their main economic activity. Only one fifth (20.9%) were in business, with even smaller proportions (4.7%, 9.1% and 2.1%) being engaged in gold mining and formal employment respectively.

The study sought to establish respondents' level of awareness on MPI in maternal health. Respondents were asked to rate the extent to which they agreed or disagreed with specific statements that describe MPI in maternal health. Their responses are captured in Table 2.

Table 2: Respondents' level of awareness of MPI on maternal health

Statement	Rating (Frequency and percentage)					Mean	SD
	1	2	3	4	5		
Men should accompany their spouses to ANC clinic on all occasions	12 (4.1)	29 (9.8)	13 (4.4)	189 (63.9)	53 (17.9)	3.82	.975
Men should accompany their spouses during labor and delivery	12 (4.1)	35 (11.8)	2 (0.7)	181 (61.1)	66 (22.3)	3.86	1.025
Men should provide for the needs of their spouses during the maternal period	23 (7.8)	48 (16.2)	19 (6.4)	187 (63.2)	19 (6.4)	3.53	1.070
Men should not beat their wives during, the maternal period.	25 (8.4)	46 (15.5)	17 (5.7)	192 (64.9)	16 (5.4)	3.43	1.082
Men should not quarrel their wives during the maternal period.	12 (4.1)	35 (11.8)	2 (0.7)	181 (61.1)	66 (22.3)	3.86	1.025
Men should provide for financial support during the maternal period.	12 (4.1)	29 (9.8)	13 (4.4)	189 (63.9)	53 (17.9)	3.82	.975
Men should support utilization of contraceptives	10 (3.4)	24 (8.1)	15 (5.1)	192 (64.9)	55 (18.6)	3.87	.907
Men should support their spouses in ARV use among HIV-positive expectant mothers	7 (2.4)	10 (3.4)	5 (1.7)	194 (65.5)	80 (27.0)	4.11	.789
Men should support their spouses to access skilled birth attendant	5 (1.7)	9 (3.0)	10 (3.4)	189 (63.9)	83 (28.0)	4.13	.755

NOTE: The figures in parenthesis are percentages

Table 2 shows that more than three quarters (81.8%) of the respondents either agreed or strongly agreed that men should accompany their spouses to ANC clinics on all occasions, with only a small proportion (13.9%) either disagreeing or strongly disagreeing. A mean score of 3.82, with a standard deviation of .975 suggests that a majority of the respondents are aware of the need for men to accompany their spouses to ANC clinic on all occasions. This finding was supported by qualitative data from FGDs, which revealed that male partners knew that they should accompany their spouses to ANC visits throughout the pregnancy.

Table 2 also indicates that a similarly large proportion of respondents (83.4%) were aware that men should accompany their spouses during labor and delivery. The results were further supported by qualitative data from FGDs. For instance, one FGD discussant said: "*We should take time to stay with our wives to show love and care, let them know that we are sharing the pain and we believe that the labor period reduces*". (FGD participant 03, Kegonga).

Furthermore, Table 2 reveals that slightly more than two thirds (69.6%) of the respondents agreed or strongly agreed that men should provide for the needs of their spouses during pregnancy, delivery and post-partum period, only a quarter (24.0%) disagreed or strongly disagreed (mean = 3.53; SD = 1.070).

However, regarding the level of awareness on psycho-social support to spouses, the study encountered a contradiction between quantitative data from the questionnaire, and qualitative information from FGDs and key informant interviews.

As can be seen in Table 2, a majority (70.3%) of the respondents agreed or strongly agreed that men should not beat their wives during pregnancy, delivery and post-partum period, with just slightly more than one fifth (23.9%) disagreeing. Furthermore, more than three quarters (83.4%) of the respondents agreed or strongly agreed that men should not quarrel their wives during pregnancy, delivery and post-partum period, with only 15.9% disagreeing. Nevertheless, despite this apparent aversion towards physical and emotional violence against female spouses during pregnancy, delivery and postnatal period, qualitative data from FGDs and key informant interviews paint a different picture. From qualitative data, it emerged that most respondents were not averse to physical and emotional violence during and after pregnancy, as confirmed by the following excerpts:

> *"We all know that beating a woman is not a crime when she has done something wrong. Women are like our big children so whenever they go wrong they are supposed to be disciplined to prevent repeat of the same."* (FGD participant 03, Matare)
>
> *"The tradition of this community makes it clear that women are regarded as children and weak creatures in the society, who should follow the rules and regulations of their husbands and the entire society. So they must be controlled by disciplining them whenever they go against that."* (FGD participant 04, Taragai)

> *"If you can't discipline our women through beating then they will think that they are above the law, which should not be the case, and that makes discipline part and parcel of us to them."* (KII participant 02- Community leader)

The apparent contradiction could be attributed to the fact that FGDs allowed for probing and challenging, whereby the researcher engaged participants in candid discussions, through which the latter were able to open up.

A similar contradiction between quantitative and qualitative data was seen with respect to male partner support for contraceptive use. While Table 2 shows that an overwhelming majority (83.5%) of the respondents agreed or strongly agreed that men should support utilization of contraceptives for their spouses, qualitative data from FGDs and key informant interviews reveals otherwise. For instance, one FGD discussants said: "*Men in this community think that when they have many children then they are rich because children are considered as sources of wealth in the society*." (FGD participant 04, Taragai)

Regarding the need for men providing financial support to their spouses during pregnancy, delivery and post-partum period, more than three quarters (81.8%) of the respondents either agreed or strongly agreed that indeed, men should provide such support. As can be seen in Table 2, a paltry 13.9% either agreed or disagreed. The findings were supported by qualitative data from FGDs, with one FGD discussant saying: "*It is the function of men to provide for the basic needs of the family and that includes all the necessities during pregnancy*." (FGD participant 01, Matare)

Similarly, Table 2 indicates that almost all respondents (92.5%) confirmed their awareness of the need for supporting their spouses in ARV adherence (mean = 4.11 SD = 0.789). Furthermore, Table 2 revealed that close to all respondents (92.7%) agreed or strongly agreed that men should support their spouses to access skilled birth attendance. This finding was however, disputed by qualitative data from KIIs, which suggested that male partners in the study area rarely accompany their spouses for delivery. According to one healthcare worker: "*It is on very rare occasions that men accompany their spouses to acquire skilled birth attendance since most women are supported by their fellow women*." (KII participant 03- Taragai)

As can be gleaned from Table 2, it is evident that an overwhelming majority of the respondents are aware of the need to be involved in maternal health, since for all the constructs save for two, more than three quarters of the respondents either agreed or strongly agreed. Even in the two constructs – men should provide basic needs; and men should not beat their wives - slightly less than three quarters of the respondents either agreed or strongly agreed.

The apparently high levels of awareness on MPI in maternal health in the study area are reflective of only a few similar findings in Africa. For instance, a study by Konde-Lule, Sekandi, Tweheyo & Tumwesigye, (2010) found that in Uganda, male partners had adequate knowledge on reproductive health and the need for them to participate in skilled birth attendances. Similarly, Meyer, Nkuoh, Nkfusai & Tih (2010) found that male partners in Cameroon had knowledge on

the need for them to provide emotional, instrumental and psychological support through avoiding quarrels and physical confrontations, which was essential for the health of women during pregnancy and their attitudes towards pregnancy and child bearing. In South Africa, Maputle, Nesane and Shilubane (2016) revealed that male partners were expected to be decision-makers within families and often had the knowledge of controlling behavior, provision of basic needs especially availability of nutritious food, women's workload during pregnancy, allocation of money, transport and time for women to attend healthcare services.

However, on the most part, many studies have reported very low levels of awareness on MPI in MCH. In Southern Asia for instance, Coe and Dolan (2011) found that male partners were not aware about the need to involve themselves in MCH, and indeed, had limited knowledge on the need for them to participate in the healthcare services of their spouses and children. Similarly, Achieng, Ameh, Dellicour, Desai, Kwambai and Person (2013) indicate that many men in low resource countries were not aware of the need to accompany their spouses to health facilities during pregnancy for ANC services. In Nigeria, Abubakar, Aliyu, Galadanci and Iliyasu (2010) found that male partners did not benefit from information from healthcare practitioners regarding the health of their spouses, or about their expected responsibilities in it, which made them not to support their partners in contraceptive use.

The apparent low levels of awareness on MPI have also been reported in Kenya. For example, Oguttu, Onyango and Owoko (2010) found that there was low level of awareness on the need for male partners to attend ANC clinics together with their spouses in western Kenya. The authors attributed the low levels of awareness to lack of reproductive health education programs in the area which promotes negative health outcomes of women and children in the region. Moreover, a study by Oguttu et al. (2010) in Western Kenya found that male partners did not understand the need to support utilization of contraceptives utilization.

Deriving from the aforementioned therefore, it is apparent that the level of awareness in MPI in maternal health among male partners in the study area is somewhat higher than the norm in Africa. This could be attributed to various factors. First, qualitative data from FGDs and KIIS revealed that the study area had been exposed to information on MPI in MCH, through seminars, workshops and health awareness trainings. "*The national government in collaboration with the county government and other non-governmental organization do hold regular trainings to provide men with the opportunities to participate in the healthcare services and children.*" (KII participant 01 - Healthcare provider)

Secondly, the apparent lack of convergence between quantitative and qualitative data on some of the constructs, points to the need for further enquiry into the same, considering the incongruence. Indeed, the divergence in findings seems to suggest that the high level of awareness might not necessarily imply high levels of male partner involvement, as can be conformed from data on actual MPI practices.

Respondents were asked to state the actual ways in which they provided support to their spouses during the maternal period. In a free listing of their involvement, it emerged that indeed, the actual practice in relation to MPI was not commensurate with the high levels of awareness, as shown in Table 3.

Table 3: Respondents' actual MPI in maternal health

Kind of Support Offered	F	%	Mean	SD
I always carry the baby whenever my wife, the baby and I go anywhere	100	33.8	3.25	1.245
I ensure there is enough food for her during pregnancy and breastfeeding	54	18.3	3.86	1.059
I cook for my spouse whenever I am able	48	16.2	3.91	1.122
I provide money for transport to and from the ANC and PNC clinic	39	13.2	3.90	0.998
I always accompany my spouse to the PNC clinic	36	13.1	3.19	1.002
I accompany my spouse to the health facility for delivery	38	12.9	3.91	1.001
I always accompany my spouse to the ANC clinic	27	11.4	3.02	0.889

This study reveals a marked discrepancy between the awareness of the need for MPI, and the actual practice in the study area. As can be seen in Table 3, only a small proportion (11.4%) of the respondents said that they usually accompany their spouses to the clinic for ANC visits. However, data in Table 2 shows that an overwhelming majority of the respondents (81.8%) either agreed or strongly agreed that men should accompany their spouses on ANC visits all the time. Similarly, while Table 2 indicates that more than two thirds of the respondents (69.6%) agreed or strongly agreed that men should provide for the needs of their spouses during pregnancy and the post-partum period, Table 3 reveals that only a small proportion stated that they actually do the same, by providing food (18.3%) and money for transport (13.2). Furthermore, as can be seen in Table 3, only 12.9% of the respondents said that they accompany their spouses to the health facility during delivery. However, Table 2 paints a different picture, with most of the respondents (83.4%) agreeing or strongly agreeing that men should accompany their spouses to a health facility for delivery.

Paradoxically, data in Table 3 shows that respondents identified only seven ways in which they provide support, yet qualitative data from FGDs and KIIs revealed that many men in the study area had been sensitized to very many ways of involving themselves in maternal health. In the words of one key informant:

> *"I personally attended one of the training sessions, in which men were sensitized on various forms of involving themselves in MCH. At that session, I remember the men identifying very many ways in which they can participate in MCH, and at the end of the session, there was general agreement that they would from then henceforth be more involved. However, actual involvement is still work in progress"* (KII discussant 03, Healthcare provider)

The discrepancy between awareness and practice could be attributed to the influence of culture. This emerged clearly from qualitative data obtained from FGDs, whereby most respondents argued that it is against Kuria culture for men to engage in some of the activities that constitute MPI in MCH. The following excerpts shed some light on this:

> *"Men go out to look for food and not staying in the house to cook for women. They can always get assistance from fellow women who will cook for them for a few days as they recover from post-delivery experiences."* (FGD participant 04, Matare)
>
> *"Here in Kuria women get assistance from their mother-in-laws and sister-in-laws. Men are not even supposed to go near where women are during child delivery."* (KII participant 02 – Community leader)

The abovementioned findings echo the results of a study on the prevalence of FGM among the Kuria, which found that while most adults in the Kuria region are aware of the dangers of FGM, they still practice it, or support its practice, because of the influence of culture (Shivachi & Ziz, 2021). Other studies have also reported similarly low levels of MPI in maternal health. For example, Arsenault, Yakes, Islam, Hossain, Ahmed, Hotz, Lewis, Rahman, Jamil and Brown (2013); and the National Institute of Population Research and Training (NIPORT) Mitra and Associates, and ICF International (2016) reported that in Bangladesh, more than half of male partners did not provide food to support their nutritional value, resulting in pregnant women being anemic, and underweight.

Similarly, in Tanzania, National Bureau of Statistics of Tanzania (2010), found that expectant mothers and mothers with young children delay in accessing health care facilities because they lack transport money and other health care related costs since they are dependent on their male partners for financial support. In Busia, Kenya, it was reported that male partners do not support their spouses to acquire skilled birth attendance and delivery services, which promotes high rates of maternal and infant mortality and morbidity, (Nanjala & Wamalwa, 2012).

It is however notable that each of the aforementioned studies also reported low levels of awareness on MPI in maternal health. In this cases therefore, corresponding levels of actual MPI are consistent with the levels of awareness. Indeed, studies that have reported high levels of awareness have also reported correspondingly high levels of awareness. For instance, in a study of sub-Saharan countries, Grady, Liu, MacDonald, Richman and Yuan (2016) found that male partners who give support to their spouses in terms of finance, cooking for their spouses and escorting them to clinic and delivery, as well as participating in making decisions, bathing their infants and carrying their children had high levels of awareness on the need for MPI in MCH. In

South Africa, Maputle, Nesane and Shilubane (2016) reported that men with more awareness of the need for MPI in MCH actively participated in making decisions on the use of contraceptives; provision of basic needs especially nutritious food and money, and created time to relieve women's workload during pregnancy, and to accompany their spouses to health facilities.

The study further sought to establish the extent to which male partners participate in deciding when to get children, with respondents being asked to state who makes the decision to get children. The results are presented in Figure 1.

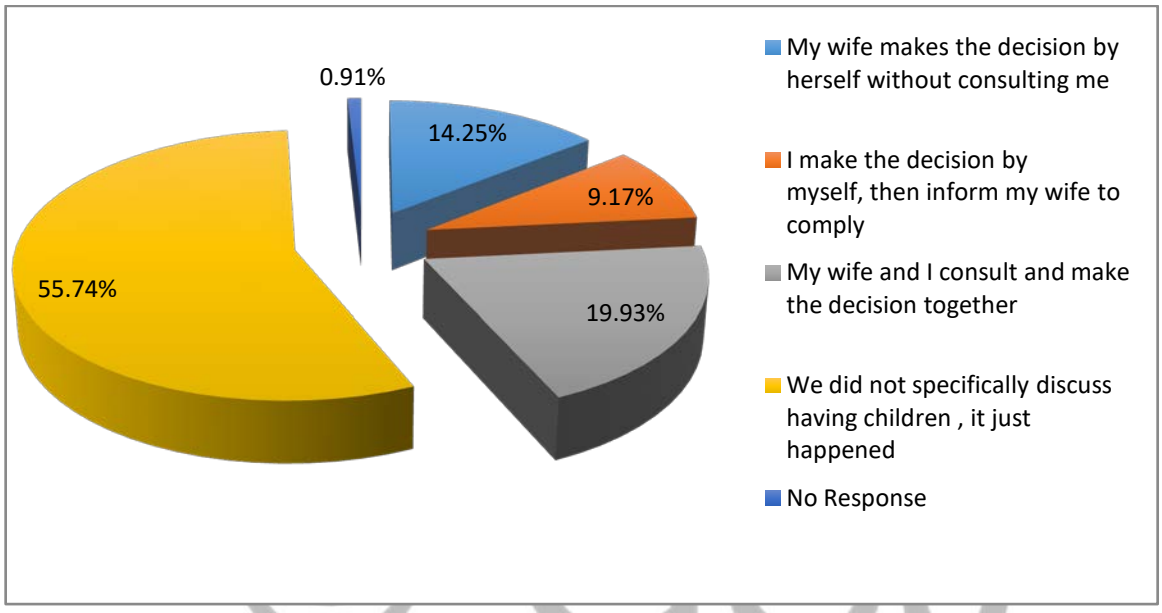

Figure 1: Decision making on utilization of MCH services

From Figure 1, it can be deduced that there is very little male partner involvement in the decision to get children in the study area. As can be seen in Figure 1, only approximately one fifth (19.93%) of the respondents discussed with their spouses about getting children, while a small proportion (9.1%) made the decision without involving their spouses. Although this might sound preposterous, qualitative data from FGDs and KIIs confirmed that indeed, some women in the study area felt compelled, by community expectations, to get children, sometimes against their wish, and even against doctors' advice. The sample of excerpts paints a clear picture of this.

> *"It is expected that women should have as many children as possible and this should not be a subject of debate."* (FGD participant, 03- Kegonga)

> *"Some things don't need to be discussed with women and so they should follow whatever they found in the community. For instance things to do with children are not issues to discuss. When women get married they know that the next step is to automatically start getting children."* (KII participart 01- Community leader)

For more than half (55.74%) of the respondents, there were no discussions on whether or not to get children. This revelation has serious implications for planned parenting (de La Rochebrochard & Joshi 2013; Carson, Redshaw, Sacker, Kelly, Kurinczuk & Quigley 2012). The lack of consultation could also impact on male partners' preparedness for pregnancy and childbearing. Notably, a significant proportion of the respondents (14.25%) reported that their spouses made the decision to get children without consulting them. This could imply that the male spouses in such incidences might be ill prepared for the financial, social and even healthcare eventualities that come with childbearing.

The study also explored other aspects of decision making for utilization of maternal healthcare services, as shown in Table 4.

Table 4 Decisions on utilization of MCH care services

Who Makes the Decision	Decision on where to go for		Average	
	ANC	Delivery	Mean	SD
Female Spouse on her Own	55.7%	30.7%	53.85 %	1.85
Male Spouse on his Own	11.1%	10.5%	10.8%	0.3
Male and Female Spouse	9.1%	32.8 %	16.2%	7.1
Relatives and Friends	24.0%	26.0%	19.1%	4.9

As can be seen in Table 4, slightly more than half of the respondents (55.7%) identified their female spouses as the ones who made decisions on where to go for ANC and PNC. Only one fifth of the respondents were involved in making the decision on where to go for ANC and PNC. Out of these, 11.1% said that they made the decision on their own, with a paltry 9.1% saying that they made the decision in consultation with their spouses. Qualitative data from FGDs and KIIs shed some light on this finding, as explained by the following excerpts.

> *"Our culture does not allow men to make key decisions regarding the healthcare services of their spouses because pregnancy and child welfare are considered domains for women."* (KII participant 02- Community leader)

> *"According to our culture, matters that concern children are left for women. Men are not supposed to decide where children will be born. If we start following up where women go for their clinics then we will be considered weak and feminine."* (KII participant 02- Community leader)

Regarding the decision on the place to go for delivery, the study reveals evidence of a slightly improved involvement of male spouses. As can be seen in Table 4, approximately one third (32.8%) of the respondents were involved in consultations on where to go for delivery. A further 10.5% of the respondents made the decision without consulting their female spouses, with less

than a third of the respondents saying that their female spouses made the decision without consulting the latter.

The greater involvement of males in making the decision on where to go for delivery could be as a result of perceptions about the dangers involved in the delivery process. A study in Nairobi, Kenya, revealed that many women from lower socioeconomic classes are scared of delivery, due to the dangers associated with it, such as the likelihood of complications that may result in poor birth outcomes such as still-births, and even death (Shivachi, Ayabei, & Sidha, 2019). This fear of the delivery process could be a contributory factor that makes women to involve men in the decision on where to go for delivery services, so that in case of any complications, the woman is not blamed. This was confirmed by qualitative data from FGDs, as can be seen in the following sampled statements:

> *"When you go for delivery, anything can happen. Women are generally afraid that if complications occur during birth, and their husband was not in the picture, she would bear the blame for choosing a "bad" health facility"* (KII participant, 02- healthcare practitioner.)

> *"Our wives must seek our opinion on where to go for delivery, because if they don't, then something goes wrong, then they will face the wrath of the husband and his family"* (KII participant, 03- Community leader)

The involvement of male partners in deciding where to go for delivery could also be as a result of the cost involved in delivery. This is because even though delivery services are provided at very low rates in government health facilities, the delivery process itself comes with various costs, such as shopping for the child, among others. This is different from ANC services, which are provided free of charge in government facilities in the study area, and do not come with any additional costs. The cost factor could be contributing to the higher involvement of male partners, since they are expected to meet these costs. As explained by some of the FGD participants:

> *"In many cases, men are the ones who provide money for the costs associated with delivery, and for this reason, they have to be involved"*. (FGD discussant 04, Taragai)

> *"In some cases, some women would like to deliver in private health facilities. They cannot do this without consulting the man, because it has cost implications"* (FGD participant 03, Matare)

Furthermore, the greater involvement of male partners in the decision on where to go for delivery could be attributed to the fact that male partners are socialized to be fathers and father figures, and their changing roles in the care for their spouses and children. The involvement could also be associated with male partners' conceptualization of social fatherhood, which encompasses the care and support of males for children especially during birth. In a similar way, the results could also be related to the safety that is required to be provided by male partners to their female

spouses during and childbirth, by ensuring access to care and provision of emotional and financial support. Further, it results to strengthening of the bond between the two spouses and also promotes a sense of teamwork and unity. According to Maluka and Peneza (2018), male partners in Tanzania make key decisions regarding maternal and child healthcare `services for their spouses and children. This include places of seeking healthcare services during delivery, help their spouses to access health facilities for delivery and meet other related costs. The results are reinforced by qualitative data in the study area, whereby the discussants revealed the following excerpts:

> *"When women are in labour they might not have the energy to think and make decision on where to go for delivery. This leaves the man with the mandate to decide where the baby will be delivered"*. (FGD participant 01- Matare)

> *Men are left with the responsibilities of deciding where their spouses will go for delivery since at that very moment the woman is in pain and the brain already fully occupied and exhausted.*" (KII participant – 04, Taragai)

This study also indicates that relatives and friends play an important role in making decisions on maternal health. As shown in Table 4, approximately one quarter of the respondents reported that relatives and friends made the decision on where to go for ANC and PNC (24.0%) and delivery (26.0%). This could be related to male patriarchal systems that hinder male spouses to make decision in the healthcare services of their spouses and children. The findings were in line with a study in Pacific by Davis et al. (2012) revealed that there was low male partner involvement in MCH regarding decision making because of high levels of gender inequality that result from strong patriarchal systems. This favors nominal male partner participation in MCH care. Thus, expectant mothers are expected to get more support from their mothers and sisters-in-law, and this includes decision making on places of delivery. The following excerpts support the finding that:

> *"Our wives get advice from their fellow women who are much older and have some experience in matters concerning reproductive health.*" (FGD participant 03- Taragai)

> *"Men work far from home thus making them to leave their expectant spouses and children in the hands of their relatives and friends, who will support them especially during labour and delivery."*(KII participant 03- Community leader)

The aforementioned findings concur with Bogale, Girma, Tilahun and Wondafrash, (2011), who found that in Ethiopia, male partners do not engage actively in decision making on matters relating to maternal and child healthcare including places of seeking healthcare services because of the belief that maternal and child healthcare is in women's docket and that it is their affair, which leads to delays in acquiring reproductive health attendance hence poor maternal outcomes. In a similar trend, Gilles, Guest, Hartmann, Kerner, Ng'ombe and Shattuck, (2011) found that in

malawi, male partners don't participate in decision making related to maternal and child healthcare including birth spacing and use of contraceptives.

In the same vein, Maluka and Peneza (2018) as well as Otengah and Shivachi (2017), found that in Tanzania and Kenya respectively, male partners were less involved in making decisions regarding maternal and child healthcare services for their spouses and children, which include places of seeking maternal healthcare services, help their spouses to access health facilities and enable appropriate utilization contraceptives.

Interestingly however, other studies have reported contradictory findings. For instance, Bhatta, (2013) found that in Nepal partners dominate the decision making power over the reproductive health on where to seek MCH services. Further, according to the study, sub-Saharan Africa, male partners did not engage actively in decision making on matters relating to maternal and child healthcare especially on places where their spouses acquire healthcare services. According to Comrie-Thomson, Tokhi, Ampt, Portela, Chersich and Khanna et al. (2015), in African traditional communities which are characterized by strong patriarchal systems, men, typically husbands, act as the major gatekeepers and primary decision-makers within households, effectively determining the care-seeking practices of women during the antenatal period, especially on places where their wives are supposed to seek for maternal and child healthcare services.

CONCLUSIONS AND RECOMMENDATIONS

The study concludes that despite the sensitization that has been conducted in the study area regarding the need for MPI in maternal health, MPI practices are still not encouraging. The low levels of MPI in the study area could be attributed to the heavy influence of culture. Both men and women in the study area still hold onto the cultural conceptualized belief on gender role specialization of pregnancy and child welfare as a domain for women. . Deriving from this, the study recommends that future MPI interventions in the study area, and other similar communities, should first focus on culture change.

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