MALE PARTNER INVOLVEMENT IN PROMOTING SKILLED ATTENDANCE AT CHILDBIRTH IN MATAYOS SUB-COUNTY, BUSIA COUNTY, KENYA

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P57/10506/2008

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF PUBLIC HEALTH IN THE SCHOOL OF PUBLIC HEALTH OF KENYATTA UNIVERSITY.

APRIL, 2016
DECLARATION

I declare that this thesis is my original work and has not been submitted for a degree in any other university or college for examination/academic purposes.

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DEDICATION

This work is dedicated to my loving husband, Henry who has practically shown me the importance of Male involvement in Reproductive Health and to my mum who has always wanted me to do some work that will contribute to the improvement of life and well-being of women and children in our country, Kenya.
ACKNOWLEDGEMENT

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To all those who may have contributed to this success in one way or the other especially the staff at the Matayos health center, the CHWs in Matayos, my Research assistants, the Statistician and the Analyst may the almighty GOD bless you all.
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ABBREVIATIONS AND ACRONYMS

ANC- Ante- Natal Clinic
AIDS -Acquired Immune Deficiency Syndrome
HIV -Human Immunodeficiency Virus
FGD – Focused Group Discussions
ICPD -International Conference on Population and Development
IMR –Infant Mortality Rate
KDHS -Kenya Demographic and Health Survey
MDG -Millennium Development Goal
MOH -Ministry of Health
RH -Reproductive Health
SBA –Skilled Birth Attendant
SPSS – Statistical Package for Social Scientists
TBAs- Traditional Birth Attendants
TM- Traditional Midwife
UN -United Nations
UNICEF –United Nations Children Education Fund
WHO -World Health Organization
DEFINATION OF TERMS

A skilled attendant: Refers to an accredited health professional during childbirth such as a midwife, doctor, or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborn. (WHO, 2004)

Eclampsia: Refers to an acute and life-threatening complication of pregnancy, is characterized by the appearance of tonic-clonic seizures, usually in a patient who had developed pre-eclampsia. (Preeclampsia and eclampsia are collectively called Hypertensive disorder of pregnancy and toxemia of pregnancy)

Hemorrhage: Refers to the excessive bleeding during and after birth referred to as Antepartum and Postpartum

Household: A person or a group of persons related or unrelated, who live together and who share a common source of food.

Neonates: A newborn child, an infant less than 4 weeks old.

Reproductive Health- the state of physical, mental, and social well-being in all matters relating to the reproductive system, at all stages of life.

Safe motherhood – a series of initiatives, practices, protocols and service delivery guidelines designed to ensure that women receive high-quality gynecological, family planning, prenatal, delivery and postpartum care, in order to achieve optimal health for the mother, fetus and infant during pregnancy, childbirth and postpartum.
ABSTRACT

Male partner involvement in women's Reproductive Health has recently garnered considerable attention. Encouraging men to promote skilled attendance during delivery is a big step in increasing the proportion of births being attended by skilled professionals hence contributing to the achievement of Millennium Development Goal 4 and 5 which aim to reduce child mortality and improve maternal health respectively. In investigating for male involvement in promoting deliveries by skilled health professionals, this study specifically aimed at: (a) establishing the socio-economic, socio-cultural and demographic factors that would influence male involvement in promoting skilled attendance during delivery and (b) explore men's knowledge of delivery complications as a precondition for choice of place of delivery and choice of assistance during delivery. In-depth interviews were conducted among males whose partners have recently given birth (0-2yrs) using a structured questionnaire. The study used descriptive research design with a target population of 200 men within the six villages of Matayos Sub-County. Secondary data was collected from the health facility records and review of the census report 2009, KDHS 2009 and KDHS 2014. Data was analyzed both quantitatively and qualitatively and results presented using frequency distribution tables and charts. A chi-square test was carried out with a p-value of <0.05 being considered significant. The study established that male involvement in promoting skilled attendance is beneficial to improving maternal outcomes. The main determinants of Male involvement in promoting skilled birth attendants were: age ($\chi^2 = 19.511, P = 0.003$); religion ($\chi^2 =13.446, P = 0.009$); marital status ($\chi^2 = 33.689, P = 0.000$); employment status ($\chi^2 =8.963, P = 0.0255$) and education level $\chi^2 =31.450, P = 0.000$. It was evident from the study that safety during delivery determines the choice of place of delivery. The study established that male partners were involved in taking care of their partners during pregnancy. Hence, recommended that programs should be introduced to reach males as well as females, not only with information and services to protect themselves and their partners, but also with messages regarding gender equity. Secondly the government should channel programs to the grassroots levels to enable those in rural areas access education on reproductive health and maternal health. They should also be freely allowed to accompany their partners to a facility in times of delivery.
CHAPTER ONE: INTRODUCTION

1.1 Background to the study

Involvement of men in promotion of safe delivery and especially skilled delivery attendance is a challenge worldwide especially in developing countries. About 210 million women become pregnant each year with 30 million (15%) developing complications, resulting into over half a million maternal deaths (Bernis et al, 2003). Developing countries account for more than 99% of all maternal deaths; about a half occurring in sub-Saharan Africa, and a third in South Asia (UNICEF, 2008). At the 1994 International Conference on Population and Development (ICPD), held in Cairo, representatives from more than 180 countries formally recognized the importance of men’s input to women’s reproductive health and also their own reproductive health.

The ICPD programme of action urges all countries to provide men, as well as women, with reproductive health care that is accessible, affordable, acceptable and convenient. It also encourages reproductive health care programmes to move away from considering men and women separately and to adopt a more holistic approach that includes men and focuses on couples. If this is adhered to, it would aid in the achievement of the 5th MDG.

Currently, there is slow progress towards achieving the 5th MDG in developing countries (AbouZahr, 2003). In Kenya, maternal mortality ratio remains unacceptably high at 488/100,000 live births. Despite a high coverage of ANC (96%), only 61% of deliveries take place within the formal health services and 62% of the deliveries are attended to by a skilled professional (KDHS 2014). A study carried out in Ngorongoro, Tanzania in order to gain an understanding of the health systems and socio-cultural factors
underlying the pattern of high use of antenatal services and low use of skilled delivery care found out that husbands typically serve as gatekeepers of women's reproductive health including decisions about where they will deliver. While husbands are encouraged to participate in programs to prevent maternal-to-child transmission of HIV, messages about the importance of skilled delivery care for all women are not given emphasis (Magoma et al, 2010). Attendance at antenatal clinics (ANCs) and receipt of professional delivery care have been associated with a reduction in maternal deaths (WHO, 2003). Getting men involved in maternal and child health care is a serious challenge because of cultural dynamics and practices (King, Maurice; 2006).

According to the World Health Report for the world health day of 2005, between 11% and 17% of maternal deaths happen during childbirth itself and between 50% and 71% in the postpartum period. About 45% of postpartum maternal deaths occur during the first 24 hours, and more than two thirds during the first week (WHO, 2005). A trained attendant present during childbirth can mean the difference between life and death both for the mother and the child. One of the reasons for women not seeking care from skilled professionals during delivery is because their male partners do not allow it (Magoma et al, 2010); this brought up the need for this study which was in search to the answers to why the male partners do not promote skilled deliveries.

1.2 Statement of the Problem

In Busia, the infant mortality is 80/1000 live births of which 45 -50% are due to neonatal deaths (KDHS 2014). The high mortality is partly attributed to low rate of deliveries by skilled personnel; only 26% of the deliveries occur at the health facilities under skilled
professionals (Dietsch, 2010). Low male involvement in maternal and child health has been cited as one of the cardinal factors contributing to low rate of deliveries at health facilities. As a country the proportion of births attended by skilled health personnel is at 62% yet the target according to MDGs is 90% in 2015 (KDHS 2014). Inability by women to deliver in a health facility under care of a skilled attendant is attributed to lack of resources, inability to make decisions on where to deliver or even lack of transport. In looking for solutions to achieving the 90%, it is important that the role of men in promoting skilled deliveries be addressed (Deaux, 2007). These, according to Dietsch, (2010) could improve the proportion of births attended by skilled personnel by 20%. Ban Ki-moon, Secretary-General of the United Nations writing in an article to the Medialoglobal newspaper said; the support of an informed husband improves pregnancy and childbirth outcomes and can mean the difference between life and death in cases of complications, when women need immediate medical care (Deaux, 2007).

1.3 Justification of the Study

Encouraging men to promote deliveries by professional birth attendants will definitely increase the proportion of babies born at health facilities under skilled attendance, and increase survival rate of neonates who otherwise perish when delivered by unskilled health attendants. Increasing the proportion of babies that are delivered in health facilities is an important factor in reducing the health risks to both the mother and the baby (KDHS, 2014). Proper medical attention and hygienic conditions during delivery can reduce the risks of complications and infection that can cause morbidity and mortality to both the mother and child.
Matayos is one of the rural areas in Busia County which according to KDHS, 2014, had the lowest use of a health facility during child birth. A high percentage of 73.3 of the deliveries were conducted at home with unskilled birth attendants (KDHS, 2014). A study by Mwangangi A. (2003) in Machakos and Nairobi showed that majority of Nairobi women delivered in Healthcare facilities while minority delivered at home. In contrast, more than half of the women delivered at home in Machakos while a small number delivered in health care facilities. This proves the fact that women in rural areas will probably not seek skilled attendance during childbirth.

In addition, a study carried out in Matayos by Omufwoko (2004) on factors influencing the performance of Community health workers in Primary health care, revealed that decision making in the area entirely lies on the men. There is therefore need to investigate the male partner involvement in promoting skilled attendance during childbirth in Kenya where the context will be Matayos sub-county.

1.4 Research Questions

This study strived to respond to the following research questions:

1. What is the influence of socio-economic and demographics on male partner involvement in promoting deliveries by skilled birth attendant?

2. What is the influence of perceived fear of complications on the choice of place of delivery and choice of assistance during delivery?

3. To what extent do the healthcare delivery systems influence male partner involvement in promoting deliveries by skilled birth attendant?

4. What are the socio-cultural aspects that influence male partner involvement in promoting deliveries by skilled birth attendant?
1.5 Objectives

1.5.1 Broad objective

The broad objective of this study was to investigate the involvement of male partners in promoting skilled attendance during childbirth in Matayos sub-county.

1.5.2 Specific objectives

1. To identify the influence of socio-economic and demographic factors on male partner involvement in promoting deliveries by skilled professionals.

2. To determine the influence of perceived fear of complications on the choice of place of delivery and choice of delivery assistance.

3. To assess the influence of selected aspects of health care delivery systems on male partner involvement in promoting deliveries by skilled professionals.

4. To assess the socio-cultural aspects that influence male partner involvement in promoting deliveries by skilled professionals.

1.6 Significance of the Study

The 5th MDG is to reduce the maternal mortality ratio by 75 percent between 1990 and 2015. It is estimated that approximately 529,000 women die every year from complications related to pregnancy or delivery (WHO, 2006). The increase of the proportion of births attended by skilled health personnel will lead to a reduction in maternal deaths as well as neonatal deaths hence very crucial in meeting the MDG 5 and MDG 4 respectively. There have been few studies done to establish why men don’t promote skilled attendance during delivery.
The study would go ahead to help the policy makers and health administrators to improve on the existing interventions to reduce maternal and child mortality rates.

1.7 Limitations and Delimitations of the Study

1.7.1 Limitations

Inadequate resources
The financial resources were limited as the study was supported by the researcher; as a result research assistants had to walk most of the time.

Long distance
The distance between homes was far apart. The research assistants walked long distances to reach the homes of respondents. This made data to be collected over a longer period of time. In some cases, respondents’ were not available in their homes at the time of the visits especially on market days. This forced the research assistants to either wait or make return visits hence time consuming and also expensive.

Poor road network
There was poor road network to the rural areas. Vehicles were also scarce in the routes to the rural areas forcing the researchers to use alternative means like motor cycle to the far places. This was also expensive.

Communication
The research assistants though locals had some challenges translating data collection tools into the local terms.
1.7.2 Delimitations

Coping mechanisms were developed by the team to overcome all the limitations that surrounded the study. The team hired motor cycles to ride to far off distances and remote areas with poor road networks to collect data. Translation and back translation of the research instruments was done during the training. The researcher also recruited research assistants who were fluent in English and could as well speak the local dialect. The team also got support from the local leaders who mobilized respondents especially during the FGDs. Reviews were done with the data collectors to address emerging issues.

1.8 The Conceptual framework

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<thead>
<tr>
<th>Independent variables</th>
<th>Dependent variable</th>
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<tr>
<td><strong>Socio-economic &amp; demographic factors:</strong></td>
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</tr>
<tr>
<td>- Education level, Income, Employment status, Age, Marital status and Parity.</td>
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<tr>
<td><strong>Knowledge of complications related to childbirth by men:</strong></td>
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<tr>
<td>- Safety during delivery</td>
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<td>- Fear of perceived complications</td>
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<td><strong>Socio-cultural factors:</strong></td>
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<tr>
<td>- Presence during delivery, Joint decision making and Religion.</td>
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<tr>
<td><strong>Influence of selected aspects of health care systems:</strong></td>
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<td>- Attitude of healthcare providers, availability, accessibility and affordability.</td>
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CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter begins with theoretical framework and empirical literature that is based on study objectives and summary.

2.2 Theoretical Review

WHO defines a Skilled birth Attendant as someone “trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (WHO, 2004).

Skilled care is the quality care to a woman during pregnancy, childbirth and postpartum period and her infant provided by a skilled personnel supported by an enabling environment (necessary equipment, supplies and medicines and infrastructure) and a functional referral system. At the centre of skilled care is a skilled attendant who is a health professional (doctor, midwife, nurse, e.t.c) equipped with the skills needed to manage normal pregnancy, childbirth and the immediate post-partum and in the referral of complications (WHO, 2005).

The 1995 UN Fourth World Conference on women, held in Beijing, encourages men to take steps towards achieving gender equality and better reproductive health. Gender differences in Kenyan society appear to have a profound effect on male involvement in reproductive health, which is usually assumed to be a woman’s concern at the household, service provision, and policy levels. Cultural beliefs also make it difficult for women to discuss matters to do with delivery with men.
Men have a very big role to play in safe motherhood. Men’s decision and actions make a difference during pregnancy, delivery and postpartum period. During pregnancy, men are to ensure that a woman gets good nutrition, plenty of rest and timely referral. They need to ensure that the woman gets proper antenatal and early care, provide transportation, provide funds to pay for the visits and learn about the symptoms of pregnancy complications.

At the time of delivery, men are to arrange for skilled care. Men can help by arranging for a trained attendant to be available for the delivery and by paying for the services. They can also arrange ahead of time for transportation and can buy supplies if necessary (Mullay et al, 2005). During the postpartum period, men can help with the household chores, encourage breastfeeding and begin using contraceptives.

### 2.3 Empirical Literature: Barriers

The main barriers to skilled attendance identified by male partners in a survey carried out in Northern Uganda were: child birth is a woman’s matter (41.7%), lack of transport means (35.8%), lack of money to pay for the services (34.1%) and fear of being tested for HIV (29.7%). Other barriers reported include; non-invitation, long waiting time at the health facility, and having a concurrent task or job demand at the same time as when they are needed (Twaheyo et al, 2010). As soon as a mother has difficulty she needs to be referred quickly for hospital treatment. So survival (prevention of death) in pregnancy and labour depends mostly on diagnosing difficulties early, and transferring a mother to hospital quickly –by any kind of transport which will take her (Maurice and Glen, 2006). In most of the rural areas, the health facilities are quite far and the roads are so poor.
2.3.1 Socio-Cultural influence on male attendance in childbirth

Social and cultural factors have a big role to play in having a skilled attendant at childbirth, according to Campbell and Graham (2006). Skilled attendance at delivery in Mexico was 81.5% of all births in the period 1994–97, but it had a level of only 58.9% in rural areas (Campbell et al., 2006). It is known that having a skilled attendant at every delivery can lead to marked reductions in maternal mortality. For this reason, the proportion of births attended by skilled health personnel is one of the indicators used to monitor progress towards the achievement of the MDG-5 of improving maternal health (Mpembeni et al., 2010).

Men involvement is needed in order to improve maternal well-being (Mullick et al., 2005). Male involvement in promoting skilled deliveries has recently been promoted as a promising new strategy for maternal health (Cohen and Burger, 2000). Since men are the primary decision maker in most families, their involvement would be very influential in promoting deliveries by skilled attendants. Mullay et al. (2005) state that involving husband/partner and encouraging couple joint decision making in maternal health may provide an important strategy in achieving women’s empowerment, which ultimately help to reduce the maternal morbidity and mortality.

Since the mid-1990s, official efforts have been made to provide skilled attendance at all births and to reduce disparities between urban and rural areas. It is one of the actions included in programmes geared to the reduction of maternal mortality, focusing on the poor population, where maternal deaths occur more frequently. Therefore, the evaluation of the effect the programme has in skilled attendance is crucial to define whether this approach is working or whether different strategies should be used to increase skilled
attendance at delivery and in turn reduce maternal mortality in Mexico (Graham et al, 2001).

2.3.2 Health Care Facility and Male Attendance in Childbirth

Health facility factors include the attitude of the health care providers and availability of well-equipped facilities. Half the world’s mothers are delivered by untrained workers called traditional birth attendants (TBAs). In Africa 60% of the mothers are delivered by unskilled workers who lack training. But even trained TBAs are not as good at preventing maternal deaths as modern health workers, especially midwives, and medical assistants. All mothers need skilled care at delivery, without which, they either die or suffer long-term disease or disability (Maurice and Glen, 2006).

Healthcare givers should be caring and kind, timely, fair, appropriate competent and avoid corruption in terms of service delivery. In a research carried out in western Kenya there were multiple instances where SBAs, armed with higher education levels, authoritative power, obstetric technology and symbolic appearances such as uniforms, exerted power in a destructive, de-humanising and abusive way over women and TMs (Dietsch, 2010). This makes the men to advice their women not to appear at the health facilities when going to deliver. Examples of rude, bullying, abusive, intimidating and even violent SBA behaviour are not limited to sub-Saharan Africa but have also been reported in literature describing maternity care in both resource-rich and resource-poor nations, including Afghanistan; Australia (Dietsch et al 2010); Laos, the Philippines and Thailand (Penwell, 2009); Mexico (Hunt et al, 2002); Nepal; UK and the USA (Regmi and Madison, 2009).
According to Maurice & Glen 2006, health care should be accessible and acceptable—many trained health workers want to work in the cities and not in the rural areas where most mothers live.

A study carried out in Tanzania involving TBAs identified the non-cooperative and disrespectful attitudes of providers in hospital settings as the top-most reason that make most clients seek the TBAs assistance (Dietsch, 2010). The TBAs attributed the continued demand for their services to the high quality and wide-ranging nature of these services, and to their sensitivity to their clientele's needs, which contrasts with the abusive treatment many women receive in hospital settings.

2.3.3 Demographic Influence on Male Attendance in Childbirth

Since childbirth preparation and use of techniques has a major impact on a woman's childbirth pain and enjoyment, a husband's willingness to participate in childbirth can be critical for the physical comfort and satisfaction of his wife's birth experience. Social class, race, family stage, and the husband-wife relationship explain about 40% of the variance in whether husbands choose to prepare for childbirth. (Hunt L et al, 2002) How much active help husbands give during labor is influenced mainly by whether the husband prepared for birth or not. Men who have already had a child and who help their wives at home, give more active assistance during labor. Race and social class affect whether a husband takes birth preparation classes, but do not have any additional impact on helpfulness during labor (Graham et al, 2001).

Men who were knowledgeable of ANC services, obtained health information from a health worker and whose spouses utilized skilled delivery at last pregnancy were more likely to accompany their spouses at ANC, unlike those who wanted to have more children.
Educational variation influences the selection of childbirth setting of the women (Chimaraoke et al, 2008). There is the confirmation that the selected childbirth settings of women with different levels of educational attainment are different. The higher a woman’s level of educational attainment the higher her probability of wanting to have an in-hospital childbirth setting and the lower the probability of her wanting to have an out of hospital childbirth setting. It is also observed that more educated women have more contributory power in reproductive matters within the family. While most uneducated (primary or no formal education) women see their husbands’ involvement in childbirth setting selection as being very important and felt childbirth setting selection right should be solely given to their husbands without contest because they (husbands) are “heads” of the family, on the contrary, women with post-secondary education and majority of those with secondary education favour a joint selection of childbirth setting by couples (husbands and wives) and they also claimed to be doing such with their husbands (Twaheyo R et al, 2010).

2.3.4 Socio-Economic Factors and Male Attendance in Childbirth

Male partner involvement during childbirth is beneficial to improving maternal outcomes. Feminist literature critiques the modern hospital-based obstetrics practices. Childbirth is generally experienced in hospital and is associated with increased and routine technological intervention. Feminist literature argues that, with the exception of risky births and women that need caesarean sections, such intervention is not a biological necessity; rather, it reflects the structure of power and decision making within obstetrical situations. The promotion of an increase of technological intervention is seen as a loss of women’s power and control over a dehumanized birth process. The history of reproductive technology is seen in term of oppression of women by science and medicine.
Economic position (income level) poses another influence on their choice of childbirth setting. There is an observed association between income level and women’s choice of childbirth setting (Agwanda A, 2006). Basically, women of high-income level were mainly found in the hospital setting while majority of those in the out-of-hospital childbirth settings is of low-income level. Almost all the out-of-hospital respondents described hospital setting as being “very costly” compared to the traditional birth setting (Twaheyo et al, 2010).

Moreover, Twaheyo also found that much knowledge or awareness of the existence of the childbirth setting also influenced the selection of childbirth setting (Twaheyo et al, 2010). The implication of this is that awareness of the existence and/or practices of childbirth setting stands not as an ultimate factor but relates with other factors to influence the selection of childbirth setting of most mothers. Safety during delivery is an important reason for choosing their respective places or centres of childbirth. Selected childbirth settings are rendering the safest form(s) of service/practice. However, the out-of-hospital patients see the safety rate of hospital settings as either equating the rate of safety of their own selected or chosen childbirth setting or slightly better in few cases (Twaheyo et al 2010).

**2.3.5 Strategies to ensure that Men Participate in Childbirth Matters**

There are several strategies that can be considered to encourage men to be involved with promoting skilled attendance. These include male friendly services, empower and educate on the importance of skilled attendance during childbirth, improvement of infrastructure and encourage consultation during decision making (Mullick et al, 2005).

**Male Friendly Services:** Men’s involvement in the health system often stops at the door to the clinic. When they accompany their partners to a facility, men may find an absence
of programs that encourage or allow them to participate (Mullick S, et al 2005). Men are concerned about preventing and treating sexually transmitted infections (STIs), yet often they do not know where treatment is available. Men also worry about impotency and infertility; they are more likely than women to work in areas with environmental or occupational hazards that can lead to reproductive health problems. However, clinics and programs, especially in remote and rural areas, focus on women’s health.

**Empower and Educate men on the Importance of Skilled Attendance during Childbirth:** Men play a crucial role in providing financial and logistic support for women in need of emergency obstetrical care, as well as post-abortion care. An educated population is a developed nation. There are so many women empowerment programmes, and the men are forgotten that they do not understand the risks of not seeking skilled attendance during childbirth (Cohen SI, 2000). Adolescent programs should seek to reach males as well as females, not only with information and services to protect themselves and their partners, but also with messages regarding gender equity. Programs are to be designed to serve men as RH clients in much the same fashion as programs have served women, consistent with the Cairo Programme of Action that called for increased attention to the individual needs of women, men, and adolescents. (Campbell et al, 2006)

**Improvement of Infrastructure:** A study by Chimaraoke and others among the urban poor in Kenya found out that the two main providers of formal obstetric care in Kenya are the state and private medical entrepreneurs. These providers are largely concentrated in urban areas, where less than 40% of Kenyans live. Most Kenyans live in remote and inaccessible rural communities and often travel very long distances to reach health facilities. Private maternal health facilities in Kenya are also often poorly equipped
(Chimaraoke et al., 2008). Many lack basic health equipment, including sterilizing units and incubators. Well-equipped private facilities are often expensive and outside the reach of poor Kenyans. Utilization of such facilities is also usually on a ‘pay-before-service’ or ‘cash-and-carry’ basis, whereby patients have to make cash deposits before treatment commences.

Stories about women, who are refused admission by private hospitals and clinics for not being able to make deposits, or for lack of evidence of a capacity to pay, are not uncommon. In some instances, when the initial deposits are exhausted, treatment is withheld and/or patients are held hostage in the hospital until further payment is made (Agwanda, 2006). Not-for-profit private providers of maternal health care services (e.g. missionary and NGO clinics and hospitals) are few in Kenya, and operate mainly in major cities. Although they are not for profit, these providers often charge user fees, making them inaccessible and unaffordable to the majority of poor Kenyans. In cases of emergency, women living in slums and rural areas are seldom able to reach such facilities (Chimaraoke et al., 2008).

Encourage Consultation during Decision Making: It is important to address the relationship between women and men and the sharing of responsibility and action. It focuses on men as supportive partners of women, and thus reflects the spirit of the ICPD document and the transformation of social roles that constrain reproductive health and rights. It emphasizes the ways services are provided and the opportunities to deliver and reinforce messages supportive of gender equity rather than specifying which RH services should be provided and to whom. RH initiatives directed toward women generally have clearly defined behavioral objectives: to increase contraceptive prevalence, to increase the use of a skilled birth attendant at delivery, to increase the use of condoms for
STI/HIV prevention, to increase the prevalence of breastfeeding, and so forth. In contrast, no single common behavioral objective underlies male involvement programs, and in some cases, they have no discernible behavioral objective. Rather, such programs view participation of males as an end in itself.

However, programs that have adopted this approach (male equity) seek to increase utilization of male-oriented RH services, the first of the objectives described below. Programs with a gender equity focus often have one or more of the remaining objectives listed below: to increase couple communication, to increase support for women’s RH practice, and to change societal gender norms that harm women’s health. With the expansion of reproductive health beyond family planning to a broader range of subjects, the potential for male involvement also increases. For example, males often play the dominant role in sexual decision-making.

2.4 Summary

This chapter has reviewed existing literature. A theoretical basis that is applicable in male attendance in childbirth has been addressed. Empirical literature based on the study objectives has also been addressed. From the literature review, we realize that a lot of emphasis has been put on Male involvement during ANC hence ANC attendance is high. Men are not involved in promoting skilled attendance during childbirth and that led us to find out the reasons as to why male partners are not involved in promoting skilled attendance during delivery.
CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter provides the methodology that was used in the research study. It explains the research study design that was employed. The chapter describes the target population, the source and types of information that were useful in meeting the objectives of the study. The methods of data collection and associated tools are well described in this chapter.

3.2 Study Design

A descriptive cross-sectional design was used to describe male involvement in promoting deliveries by professional birth attendants. This study design was chosen because it enables one to observe, describe and document aspects of a situation as it naturally occurs in a given population, which is the main aim of this study.

3.3 Study Variables

3.3.1 Dependent variable

The dependent variable of this study was Male involvement in promoting skilled attendance at childbirth.

3.3.2 Independent variables

The independent variables of this study included Socio-economic and demographic characteristics (Education level, Income, Employment status, Age, Marital status and Parity) Knowledge of complications related to childbirth by men, Socio-cultural factors and Influence of selected aspects of health care systems.

3.4 Study Site

Matayos Sub-county is located along the Kenya-Uganda highway in Busia County, Western province, Kenya. (Appendix 1) It has an approximate population of 56,185
people out of which 29,200 are men (Census 2009). The area is served by 1 health centre and 2 dispensaries, (Kenya health facility list, 2010). Apart from the main Kisumu – Busia road, all the other roads are in poor conditions especially during the rainy season. The area was a location but has since been upgraded to a division.

3.5 Study Population

The population targeted comprised male partners who recently had a child (not more than two years old). Mugenda and Mugenda, (2003), explain that the target population should have some observable characteristics, to which the researcher indents to generalize the results of the study. This is the reason for specifying the child bearing age.

3.6 Inclusion and Exclusion criteria

3.6.1 Inclusion criteria

Included in the study were men who were over 18 years of age and in a position to give written or verbal consent to participate in the research. In addition, their partner/spouse should have given birth in the last two years before the survey.

3.6.2 Exclusion criteria

Excluded in the study were men under the age of 18 years (minors) and men whose partners gave birth to the last child more than two years ago.
3.7 Sampling Techniques and Sample size Determination

3.7.1 Sample Size Determination

The 10% Gay Principle (Mugenda and Mugenda 2003) was adopted for computation of sample size. With a target population of 1826 according to the census report 2009 and community strategy units records, the sample size was 183 rounded off to 200 to cover up for non-response.

3.7.2 Sampling Techniques

Both probability and non-probability techniques were applied. Purposive sampling was used to target only men who are the subject of the study. Cluster sampling was considered because the population of interest was subdivided into 5 villages. After which a simple random was carried out to get the sample in each village. The men were sampled from each of the villages to ensure equal representation as shown in the table below:

<table>
<thead>
<tr>
<th>Location(cluster)</th>
<th>Target population</th>
<th>Percentage</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nang’oma</td>
<td>365</td>
<td>20%</td>
<td>37(40)</td>
</tr>
<tr>
<td>Bukhayo west</td>
<td>383</td>
<td>21%</td>
<td>38(42)</td>
</tr>
<tr>
<td>Nasewe</td>
<td>329</td>
<td>18%</td>
<td>33(36)</td>
</tr>
<tr>
<td>Busibwabo</td>
<td>329</td>
<td>18%</td>
<td>33(36)</td>
</tr>
<tr>
<td>Lwanya</td>
<td>420</td>
<td>23%</td>
<td>42(46)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1826</strong></td>
<td><strong>100%</strong></td>
<td><strong>183(200)</strong></td>
</tr>
</tbody>
</table>
3.8 Construction of Research instruments

This study applied both quantitative tools such as questionnaires and qualitative tools such as key informant interviews and Focus group discussion guides to collect data from the respondents. Construction of research instruments was based on the study objectives, literature review and study variables.

3.9 Ensuring Validity

To ensure validity a pre-test study was carried out to clarify ambiguities in the data collection tool. This helped ensure accurate answers were obtained during the actual study. The research assistants were trained to carry out the exercise effectively and data collection was closely supervised.

3.10 Data Collection Methods

Primary Data was collected by the use of interviews using structured questionnaires (Appendix 3). There were also Focused group discussions with the Community Health workers (CHWs) in the Division.

Secondary data was collected from the health facility records and review of the census report 2009, KDHS 2009 and the Kenya health facilities list.

3.11 Logistical and Ethical Considerations

The study obtained ethical approval from Kenyatta University graduate School and a research permit from the ministry of Science and technology, Written informed consent was obtained from all respondents aged 18 years and above, seeking their voluntary
participation. The information given in each and every questionnaire was handled confidentially.

3.12 Data Analysis and Presentation

As a result of the nature of data sought, data was analyzed both quantitatively and qualitatively. SPSS and MS Excel computer software were used to analyze the quantitative data. Qualitative data was coded and analyzed according to the theme and presented by use of frequency distribution tables, charts and results generated as percentages. Chi-square statistic was used to test the association between variables.
CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter presents the findings of the study based on the data collected from the field. The first section presents background characteristics of respondents and the second section presents the results of Chi-square tests used to measure associations between Socio-cultural, socio-economic, demographic, healthcare factors and Male partner involvement in promoting skilled attendance during childbirth in Matayos.

4.2 Background characteristic of the Respondents

In order to capture the general information of the respondents, age, marital status, parity, level of education, religion, type of marriage, employment status, income and number of children were addressed in this section.

4.2.1 Demographic characteristic of the Respondents

The cumulative age profile showed that most of the respondents’ age ranged between 26 and 40 years (43%), while 41-55 years were 26.5%. On education most of the respondents (43.5%) had attained secondary education while 37.5% had attained up to primary level. On the issue of religion, a cumulative of 50% indicated that they were Catholics while 33% were Protestants. Majority of the respondents 90% were married while 79.5% were in a monogamous marriage. Concerning Employment, 84.5% of the respondents indicated that they were self-employed. On parity, majority of them indicated that they had 3-4 children and this was represented by forty two percent.
Table 4.1 Demographic characteristic of the Respondents (n=200)

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 25</td>
<td>43</td>
<td>21.5</td>
</tr>
<tr>
<td>26-40</td>
<td>86</td>
<td>43.0</td>
</tr>
<tr>
<td>41-55</td>
<td>53</td>
<td>26.5</td>
</tr>
<tr>
<td>Over 55</td>
<td>18</td>
<td>9.0</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highest level of Education</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>13</td>
<td>6.5</td>
</tr>
<tr>
<td>Primary</td>
<td>75</td>
<td>37.5</td>
</tr>
<tr>
<td>Secondary</td>
<td>87</td>
<td>43.5</td>
</tr>
<tr>
<td>College</td>
<td>24</td>
<td>12.0</td>
</tr>
<tr>
<td>University</td>
<td>1</td>
<td>.5</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>66</td>
<td>33.0</td>
</tr>
<tr>
<td>Muslim</td>
<td>34</td>
<td>17.0</td>
</tr>
<tr>
<td>Catholic</td>
<td>100</td>
<td>50.0</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>1</td>
<td>.5</td>
</tr>
<tr>
<td>Married</td>
<td>180</td>
<td>90.0</td>
</tr>
<tr>
<td>Divorced</td>
<td>13</td>
<td>6.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Marriage</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monogamy</td>
<td>143</td>
<td>79.5</td>
</tr>
<tr>
<td>Polygamy</td>
<td>37</td>
<td>20.5</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>24</td>
<td>12.0</td>
</tr>
<tr>
<td>Self Employed</td>
<td>169</td>
<td>84.5</td>
</tr>
<tr>
<td>Any other</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>42</td>
<td>21.0</td>
</tr>
<tr>
<td>3-4</td>
<td>84</td>
<td>42.0</td>
</tr>
<tr>
<td>5</td>
<td>69</td>
<td>34.5</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>
4.2.2 Type of Income Generating Activity

Majority of the respondents indicated that their major type of income generating activity was farming and business. On the other hand some revealed that they generated income from businesses such as carpentry, cane cutting and sugarcane selling, repairing mobiles and transport using boda boda.

4.3 Social –Cultural Characteristics

4.3.1 Involvement in Taking Care of the Partner during Pregnancy

The study established that 86% agreed that the male partner was involved in taking care of their partners during pregnancy. Further 12% disagreed that the male partner took care of the other partner during pregnancy. Only 2% did not respond.
4.3.2 Presence during Last Child’s Delivery

The researcher further sought to find the reasons why the male partners were not present during the last child’s delivery. Figure 4.3 below shows the results.

4.3.2.1 Reasons for their Absence

Figure 4.1 Involvement in Taking Care of the Partner during Pregnancy

Figure 4.2 Presence during Last Child’s Delivery

Figure 4.3 Reasons for absence
The study established that men in Matayos Division believe Childbirth is woman’s business as indicated by 76% of the respond. 6% indicated that they had other commitments e.g at work. While 5% revealed that the wife was at the parent’s house respectively. Further 4% indicated that it was not necessary. However 10% of the respondents said they were not allowed by the attendant.

4.3.3 Participation on their Partner’s Wellbeing

The study established that 84% indicated that the effect of their participation on their partner’s wellbeing was positive while 9% revealed that the effect of their participation was negative. Further 2% said that their there no effect in their participation on their partner wellbeing.

Figure 4.4 Participation on their Partner’s Wellbeing
4.3.4 Joint Decisions made on delivery attendance

Figure 4.5 Joint Decisions made on delivery attendance
Figure 4.5 shows that 14% agreed that the both partners were involved in making joint decisions on who to attend to them during delivery while 86% disagreed that their partners were involved in making decisions on delivery attendance.

4.4 Health Care Characteristics

The study sought to show how the availability, accessibility and affordability of health care facilities affected the involvement of male partners in promoting skilled attendant during childbirth. It also sought out the impact created by the attitude of various health care providers to the male partners.

4.4.1 Health Facility in the Area

Figure 4.6 Health Care Facility in the Area
The study established that there was health facility in the study area shown by a 96% of the respondents.

4.4.2 Distance to the Nearest Health Care Facility

The study also established that 26% of the respondents’ households were 1-2km to the nearest health facility while 16% revealed that it was 0-1 km to the nearest health facility. A majority of 58% said that the nearest health facility was 3km and above.

Figure 4.7 Distance to the Nearest Health Care Facility

4.4.3 Attitude of the Health Care Providers towards Patients at the Health Facility

Figure 4.8 Attitude of the Health Care Providers towards Patients at the Health Facility
According to the findings in figure 4.8, 59% of the respondents felt that the health care providers had a negative attitude towards patients at the health facility. Further 23% felt that the health care providers had positive attitude towards patients at the health facility while 18% thought it was neutral.

### 4.4.4 Health Care Facility and Male Involvement in choice of skilled attendant

<table>
<thead>
<tr>
<th>Table 4.2 Health Care Facility and Male Involvement in Childbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well-equipped facilities are available at the health facility</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>26 (13.0)</td>
</tr>
<tr>
<td><strong>The attitude of health care providers discourages husbands to participate in seeking maternal health care</strong></td>
</tr>
<tr>
<td>12 (6.0)</td>
</tr>
<tr>
<td><strong>Non-cooperation care of providers in hospital settings make most clients seek the assistance from TBAs</strong></td>
</tr>
<tr>
<td>17 (8.5)</td>
</tr>
<tr>
<td><strong>TBAs are sensitive to their clientele's needs thus the continued demand for their service</strong></td>
</tr>
<tr>
<td>15 (7.5)</td>
</tr>
<tr>
<td><strong>Fear of being tested for HIV hindered me from accompanying my wife to the clinic</strong></td>
</tr>
<tr>
<td>52 (26.0)</td>
</tr>
<tr>
<td><strong>Long waiting time at the health facility</strong></td>
</tr>
<tr>
<td>22 (11.0)</td>
</tr>
</tbody>
</table>
Table 4.2 shows that 45% agreed that well equipped facilities are available at the health facility. On the other hand 48.5% agreed that bad attitude of health care providers discourages husbands to participate in seeking maternal health care. Moreover 44.5% agreed that non-cooperation care of providers in hospital settings make most clients seek the assistance from TBAs. Finally 51.5% agreed that TBAs are sensitive to their clientele's needs thus the continued demand for their service. In addition 46.5% revealed that fear of being tested for HIV hindered them from accompanying their wife to the clinic to a very great extent. Lastly 36.5% indicated that long waiting time at the health facility was a hindrance to a great extent.

**Table 4.3: Influence of Healthcare Facilities**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of health facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>192</td>
<td>96%</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>4%</td>
</tr>
<tr>
<td>Distance to health facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-1 km</td>
<td>32</td>
<td>16%</td>
</tr>
<tr>
<td>1-2 km</td>
<td>52</td>
<td>26%</td>
</tr>
<tr>
<td>3km &amp; above</td>
<td>116</td>
<td>58%</td>
</tr>
<tr>
<td>Attitude of health care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutral</td>
<td>36</td>
<td>18%</td>
</tr>
<tr>
<td>Negative</td>
<td>118</td>
<td>59%</td>
</tr>
<tr>
<td>Positive</td>
<td>46</td>
<td>23%</td>
</tr>
<tr>
<td>Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>172</td>
<td>86%</td>
</tr>
<tr>
<td>Moderate</td>
<td>22</td>
<td>11%</td>
</tr>
<tr>
<td>Low</td>
<td>6</td>
<td>3%</td>
</tr>
</tbody>
</table>
4.5 Socio-economic Characteristics

4.5.1 Influence of Economic Position of the Family to the Choice of Childbirth Setting

![Figure 4.9 Influence of Economic Position of the Family to the choice of Childbirth Setting.](image)

The study established that 88% agreed that the economic position of the family influenced the choice of childbirth setting while 12% disagreed that the economic position of the family influenced the choice of childbirth setting.

4.5.2 Influence of Income Level on Choice of Hospital Delivery

![Figure 4.10 Influence of Income Level on Choice of Hospital Delivery](image)

According to Figure 4.10 above, the findings show that 64% agreed that men of high income level have their women go for hospital delivery while, majority of those who go
for out of hospital are of low income level. Further 15% strongly agreed that men of high income level take their women for hospital delivery. On the contrary 16% disagreed that men of high income level go for hospital delivery while, majority of those who go for out of hospital are of low income level. On the other hand 1% strongly disagree to this statement. However 2% were not sure whether men of high level of income go for hospital delivery.

4.5.3 Level of agreement on Educational Influence on Selection of Childbirth Setting

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>29</td>
<td>14.5</td>
</tr>
<tr>
<td>Not sure</td>
<td>26</td>
<td>13.0</td>
</tr>
<tr>
<td>Agree</td>
<td>72</td>
<td>36.0</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>70</td>
<td>35.0</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.4 Level of agreement on Educational Influence on Selection of Childbirth Setting

According to the findings, 36% agreed that men with post-secondary education and majority of those with secondary education favor a joint selection of childbirth setting by couples. Further 35% strongly agreed to this statement. On the contrary 14.5% disagreed while 13% were not sure that men with post-secondary education and majority of those with secondary education favor a joint selection of childbirth setting by couples.
4.6 Perceived Fear of Complications and Male Partner Involvement in Promoting Deliveries by Skilled Professionals

4.6.1 Awareness of Maternal Deaths over the Last 3 Years

The study established that 66% of the respondents agreed that they were aware of maternal deaths in the area for over the last three years. However 34% disagreed that they were aware of any maternal deaths over the last three years.

![Figure 4.11 Awareness of Maternal Deaths over the Last 3 Years](image)

4.6.2 Trend of Maternal Deaths

The researcher further sought to find the trend of maternal deaths in the area for the last three years. Figure 4.12 shows the results of the findings.
Figure 4.12 Trends in Maternal deaths

Figure 4.12 above shows that 35% indicated that the trends of maternal deaths in the area were very low while 34% indicated that they were low. Further 18% indicated that the trend was high while 3% revealed that the trend was moderate. On the other hand 2% said that the trend was very high.

4.6.3 Perceptions on reduction of Maternal Death at every Delivery by Skilled Attendant

Figure 4.13 Reduction of Maternal Death at every Delivery by Skilled Attendant

Figure 4.13 above shows that 93% agreed that a skilled attendant at every delivery lead to marked reductions in maternal death while 6% disagreed that the skilled attendant lead to reductions in maternal death. However 1% did not respond.
4.6.4 Determination of Choice of Childbirth by Safety

![Pie chart showing 93% agreed and 7% disagreed]

Figure 4.14 Determination of Choice of Childbirth by Safety

Figure 4.14 shows that 93% agreed that safety during delivery determined the choice of the respective places or centers of childbirth. However, 7% disagreed that safety during childbirth determines the choice of the centers of childbirth.

4.6.5 Equipment and Facilities for Delivery

This section of the study sought to show whether facilities available for childbirth are well equipped to cater for any complications during delivery. Figure 4.15 below shows the findings.

![Bar chart showing 67% yes and 33% no]

Figure 4.15 Equipment and Facilities for Delivery
According to the findings, 67% agreed that facilities were available for childbirth and that they were well equipped to cater for any complications during delivery. On the other hand 33% disagreed that facilities were available and that they were well equipped to cater for any complications during delivery.

### 4.6.6 Safety during Delivery Affecting Choice of Attendance

Table 4.5 Level of Agreement on Safety during Delivery

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Disagree</td>
<td>8</td>
<td>4.0</td>
</tr>
<tr>
<td>Agree</td>
<td>138</td>
<td>69.0</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>47</td>
<td>23.5</td>
</tr>
<tr>
<td>No response</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The study established that 69% agreed that safety during delivery determined the choice of the respective places or centers of childbirth. Further 23.5% strongly agreed to this statement. However 1% and 4% disagreed and strongly disagreed that safety during delivery determined the choice of the respective places or centers of childbirth.

### 4.6.7 Perceived Fear of Complications Leads to Choice of Place of Delivery

According to the findings in figure 4.16, 97% agreed that fear of complications leads to their choice of place of delivery and choice of assistance during delivery. However 3% disagreed that fear of complications lead to choice of place of delivery.
Figure 4.16 Perceived Fear of Complications Leads to Choice of Place of Delivery

4.6.8 Level of Agreement on Perceived fear of Complications

Table 4.6 Level of Agreement on Perceived Level of Complications

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>8</td>
<td>4.0</td>
</tr>
<tr>
<td>Agree</td>
<td>102</td>
<td>51.0</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>90</td>
<td>45.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

According to the study, 51% agreed that perceived fear of complications lead to choice of place of birth while this was concurred by 45% who strongly agreed. Only 4% disagreed that perceived fear of complications lead to choice of place of delivery.

4.6.9 Delivery setup where Complications are greatest

Figure 4.17 below shows that 38% indicated that complications were greatest in TBAs while 11% revealed that complications were greatest in deliveries by skilled professionals. However 51% indicated that other assistance during delivery caused more complications.
4.7 Chi-square Tests to determine associations

4.7.1 Chi-square tests between dependent and Independent variables

This is to test if there is relationship between the socio-demographic characteristics, socio-economic characteristics, Health care delivery service, socio-cultural characteristics and male partner involvement in promoting skilled attendance at childbirth. In this study the main statistical technique used in testing the relationship between the aforementioned variables was the Pearson’s chi square test statistic. The decision rule in this study was that, test results showing $p < 0.05$ at 95% confidence level meant that there is a statistically significant relationship while if the test results were higher than the set alpha of 0.05 (i.e. $p>0.05$), then it would mean there exists no statistical significant relationship between the two variables. The results for the tests are as presented below.
### 4.7.1.1 Socio-cultural factors and male partner involvement

**Table 4.7: Chi-Square Tests for Relationship between Socio-cultural factors and male partner involvement**

<table>
<thead>
<tr>
<th></th>
<th>Male partner involvement</th>
<th>Chi-square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (N (%))</td>
<td>No (N (%))</td>
</tr>
<tr>
<td>Religion:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>50 (75.8)</td>
<td>16 (24.2)</td>
</tr>
<tr>
<td>Muslim</td>
<td>5 (14.7)</td>
<td>29 (85.3)</td>
</tr>
<tr>
<td>Catholic</td>
<td>37 (37)</td>
<td>63 (63)</td>
</tr>
<tr>
<td></td>
<td>$\chi^2 = 13.446$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>df = 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$p = 0.009$</td>
<td></td>
</tr>
<tr>
<td>Joint decision:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26 (92.9)</td>
<td>2 (7.1)</td>
</tr>
<tr>
<td>No</td>
<td>38 (22.1)</td>
<td>134 (77.9)</td>
</tr>
<tr>
<td></td>
<td>$\chi^2 = 11.93$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>df = 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$p = 0.007$</td>
<td></td>
</tr>
<tr>
<td>Presence during delivery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>40 (100)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>No</td>
<td>13 (8.1)</td>
<td>147 (91.9)</td>
</tr>
<tr>
<td></td>
<td>$\chi^2 = 24.02$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>df = 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$p = 0.001$</td>
<td></td>
</tr>
</tbody>
</table>

Chi-square test results ($\chi^2 = 13.446$, df = 4, $p = 0.009$) for Religion, ($\chi^2 = 11.93$, df = 4, $p = 0.007$) for Joint decision making and ($\chi^2 = 24.02$, df = 4, $p = 0.001$) for presence during delivery in Table 4.8 show that there was an association between socio-cultural factors and male partner involvement since $p<0.05$ at 95% confidence level. It was therefore concluded that socio-cultural factors have significant contribution towards male partner involvement in promoting skilled attendance at childbirth.
4.7.1.2 Socio-economic factors and male partner involvement

Table 4.8: Association between between Socio-Economic Factors and male partner involvement

<table>
<thead>
<tr>
<th>Factors</th>
<th>Male involvement</th>
<th>(\chi^2) (df) P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1 (7.7)</td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>25 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>43 (49.4)</td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>20 (83.3)</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>1 (100)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 (92.3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>52 (66.7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>44 (50.6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 (16.7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(\chi^2 = 31.450)</td>
<td>(8) p=0.000</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 1000</td>
<td>18 (94.7)</td>
<td></td>
</tr>
<tr>
<td>1000-5000</td>
<td>102 (85)</td>
<td></td>
</tr>
<tr>
<td>5000-10000</td>
<td>15 (34.9)</td>
<td></td>
</tr>
<tr>
<td>Above 10000</td>
<td>16 (88.9)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>151 (100)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 (5.3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18 (15)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>28 (65.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 (11.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>49 (100)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(\chi^2 = 24.02)</td>
<td>df=3 p=0.001</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>23(95.8)</td>
<td></td>
</tr>
<tr>
<td>Self employed</td>
<td>62(36.7)</td>
<td></td>
</tr>
<tr>
<td>Any other</td>
<td>2(40)</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>0(0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1(4.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>107(63.3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3(60)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2(100)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(\chi^2 = 8.963)</td>
<td>df=7 p=0.0255</td>
</tr>
</tbody>
</table>

Chi-square test results (Table 4.9) above between socio-economic factors and male partner involvement where Education has \(\chi^2 = 31.450\), df = 8, p = 0.000, Income has \(\chi^2 = 24.02\), df = 3, p = 0.001 and Employment status has \(\chi^2 = 8.963\), df = 7, p = 0.0255 meant that there was a statistical significant relationship between socio-economic factors and male partner involvement since p>0.05. This was taken to imply that socio-economic factors do contribute a lot to male partner involvement in promoting skilled attendance at childbirth.
4.7.1.3 Socio-demographic Factors (Age, Marital Status and Parity) and male partner involvement in promoting skilled attendance at childbirth

As concerns relationship between the socio-demographic factors and male partner involvement, chi-square results showed that there is a statistically significant relationship between age and male partner involvement $\chi^2 = 19.511$, $P = 0.003$; marital status and male partner involvement $\chi^2 = 33.689$, $P = 0.000$ and parity and male partner involvement $\chi^2 = 32.209$, $P = 0.120$ (Table 4.10). Therefore, it was concluded that indeed the socio-demographic factors thus age and marital status have statistical significant relationship with male partner involvement in promoting skilled attendance at childbirth while the association between parity and Male partner involvement was no statistically significant.

**Table 4.9: Cross tabulation results between Age and male partner involvement in promoting skilled attendance at childbirth**

<table>
<thead>
<tr>
<th>Factors</th>
<th>Male Partner involvement</th>
<th>$\chi^2$ (df)</th>
<th>$P$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (N (%))</td>
<td>No (N(%))</td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>20 (47.6)</td>
<td>22 (52.4)</td>
<td>$\chi^2 = 32.209$ (6)</td>
</tr>
<tr>
<td>3-4</td>
<td>32 (38.1)</td>
<td>52 (61.9)</td>
<td>$P = 0.120$</td>
</tr>
<tr>
<td>5-6</td>
<td>19 (27.5)</td>
<td>40 (72.5)</td>
<td></td>
</tr>
<tr>
<td>7 and more</td>
<td>2 (40)</td>
<td>3 (60)</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>0 (0)</td>
<td>1 (100)</td>
<td>$\chi^2 = 33.689$ (8)</td>
</tr>
<tr>
<td>Married</td>
<td>131 (72.8)</td>
<td>49 (27.2)</td>
<td>$P = 0.001$</td>
</tr>
<tr>
<td>Divorced</td>
<td>7 (53.8)</td>
<td>6 (46.2)</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>1 (16.7)</td>
<td>5 (83.3)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 25</td>
<td>28 (65.1)</td>
<td>15 (34.9)</td>
<td>$\chi^2 = 19.511$ (6)</td>
</tr>
<tr>
<td>26-40</td>
<td>56 (65.1)</td>
<td>30 (34.9)</td>
<td>$P = 0.002$</td>
</tr>
<tr>
<td>41-55</td>
<td>5 (9.4)</td>
<td>48 (90.6)</td>
<td></td>
</tr>
<tr>
<td>Over 65</td>
<td>10 (55.6)</td>
<td>8 (44.4)</td>
<td></td>
</tr>
</tbody>
</table>
4.7.1.4 Perceived fear of complication and male partner involvement

Table 4.10: Chi-Square Tests for relationship between perceived fear of complication in promoting skilled attendance at child birth

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Male involvement</th>
<th>Chi-square</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes (%)</td>
<td>No (%)</td>
<td></td>
</tr>
<tr>
<td>Safety during delivery determines place of delivery</td>
<td>Yes 78(34.4)</td>
<td>No 122(65.6)</td>
<td>χ² = 6.61</td>
</tr>
<tr>
<td></td>
<td>1(7.1)</td>
<td>13(92.9)</td>
<td>df =1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>p = 0.01</td>
</tr>
<tr>
<td>Delivery set-up where complications are greatest</td>
<td>Yes 4(18.2)</td>
<td>No 18(81.8)</td>
<td>χ² = 7.56</td>
</tr>
<tr>
<td></td>
<td>20(26.3)</td>
<td>56(73.7)</td>
<td>df =1</td>
</tr>
<tr>
<td></td>
<td>32(31.4)</td>
<td>70(68.6)</td>
<td>p = 0.006</td>
</tr>
<tr>
<td>Knowledge of complications</td>
<td>Yes 43(38.4)</td>
<td>No 69(61.6)</td>
<td>χ² = 4.966</td>
</tr>
<tr>
<td></td>
<td>12(13.6)</td>
<td>66(86.4)</td>
<td>df =1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>p = 0.026</td>
</tr>
</tbody>
</table>

The Chi-square test results (Table 4.11) above between perceived fear of complications and male partner involvement where χ² = 6.61, df = 1, p = 0.01, represents safety during delivery and Delivery set-up where complications are greatest has χ² = 7.56, df = 1, p = 0.006. Knowledge of complications has χ² = 4.996, df = 1, p = 0.026 meant that there was a statistical significant relationship between perceived fear of complications and male partner involvement since p>0.05. This was taken to imply that perceived fear of complications greatly contributes to male partner involvement in promoting skilled attendance at childbirth.
CHAPTER FIVE
DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter provides a summary of the findings; the conclusion and the recommendations of the study which sought to investigate the male partner involvement in promoting skilled attendance during childbirth in Matayos Division.

5.2 Summary

This section of the study gives a summary of the key findings in relation to the specific objectives. The study found out that majority of the male partners were in a monogamous marriage and they were involved in income generating activities such as farming and trading.

5.2.1 Influence of Socio-economic and Demographics on Male Partner Involvement in Promoting Deliveries by Skilled Professionals

Chi-square results showed that there is a statistically significant relationship between age and male partner involvement $\chi^2 = 19.511$, $P = 0.003$; religion and male partner involvement $\chi^2 = 13.446$, $P = 0.009$; marital status and male partner involvement $\chi^2 = 33.689$, $P = 0.000$; employment status and male partner involvement $\chi^2 = 8.963$, $P = 0.0255$ and education level and male partner involvement $\chi^2 = 31.450$, $P = 0.000$.

The study established that male partners agreed that the economic position of the family influenced the choice of childbirth setting and that involvement in promoting skilled attendance was beneficial to improving maternal outcomes. It was evident that men of high income level take their women for hospital delivery while, majority of those who go for out of hospital are of low income level. The study established that male involvement in promoting skilled attendance is beneficial to improving maternal
outcomes. Further Economic position (Income level) of the family influences the choice of childbirth attendance. Besides awareness of the existence of the childbirth setting influence the selection of the childbirth setting. In addition the respondents indicated that social class and family stage did not have much impact on their choice to preparation of childbirth. However a good number felt that husband-wife relationship had a great impact on the choice to preparation of childbirth. According to the findings, the respondents agreed that male partner's willingness to participate in childbirth brings physical comfort and satisfaction of his wife. It was evident that Men who have already had a child give more active assistance during labour. On the other hand men who were knowledgeable of skilled attendant’s services are likely to promote it and educated men have more contributory power in reproductive matters within the family. On the contrary some disagreed that male involvement during labor is influenced by whether the husband prepared for birth.

5.2.2 Perceived Fear of Complications on Male Partner Involvement in Promoting Deliveries by Skilled Professionals

It was evident from the study that safety during delivery determines the choice of the respective places or centers of childbirth. Facilities were available for childbirth and that they were well equipped to cater for any complications during delivery. Male partners agreed that fear of complications leads to their choice of place of delivery and choice of assistance during delivery. The study further revealed that complications were greatest in TBAs while few in deliveries by skilled professionals.

5.2.3 Selected aspects of Health Care systems and Male Involvement in Childbirth

Results of the study show that there are health facilities in the area but accessibility and affordability hindered clients from using them. This agrees with the study done by
Omufwoko (2004) in the same area on Factors influencing the performance of CHWs in Primary health care. Majority of the respondents agreed that there was a health facility and the distance to the nearest was 1-2 km. at the same time the study found out that the cost is high at a health facility than when using TBA services. Hence, the study found out that most of the women are delivered by untrained traditional birth attendants since they are accessed easily and they are affordable. On the other hand the male partners agreed that bad attitude of health care providers discourages husbands to participate in seeking maternal health care. This is in line with a study carried out in Tanzania involving TBAs which identified the non-cooperative and disrespectful attitudes of providers in hospital setting as the most important issue that make most clients seek their assistance (Diestch, 2010). Finally TBAs are sensitive to their clientele's needs thus the continued demand for their service. In addition male partners revealed that fear of being tested for HIV hindered them from accompanying their wife to the clinic to a very great extent. Lastly it was evident that there long waiting time at the health facility.

5.2.4 Socio-Cultural Influence on Male Involvement in Childbirth

Chi-square test results in Table 4.8 show that there was a statistical significant relationship between socio-cultural factors (Religion, joint decision making and presence during delivery) and male partner involvement since p<0.05 at 95% confidence level. It was therefore concluded that socio-cultural factors have significant contribution towards male partner involvement in promoting skilled attendance at childbirth.

The study established that male partners were involved in taking care of their wives during their pregnancy but were not involved during childbirth. This tally with a study carried out by Magoma et al in Tanzania on use of Ante natal care which found out that ANC attendance was very high as compared to skilled attendance during delivery. They
revealed that majority of the men did not encourage joint decision making on maternal health. According to the findings, men Involvement is needed in order to improve maternal well-being to a great extent. Further, skilled attendant at every delivery lead to marked reductions in maternal mortality to a great extent. On the other hand involving both partners and encouraging couple joint decision making in maternal health provide an important strategy in achieving women’s empowerment.

5.2.5 Social-economic Influence on Male Involvement in Childbirth

Chi-square test results between Socio-Economic Factors (Income, Education level and Employment status) and male partner involvement meant that there was a statistical significant relationship between Socio-Economic Factors and male partner involvement since $p>0.05$. This was taken to imply that socio-economic factors do contribute a lot to male partner involvement in promoting skilled attendance at childbirth.

5.3 Results from Focused Group Discussion.

From the Focused Group Discussions that were carried out, a number of factors were found to encourage home deliveries. This included;

Tense and unfriendly health facility environment; It came out that the caregivers at the health facilities are not friendly hence most men would prefer not to use their services. Religious convictions also hindered the use of a health facility in addition to the cost implications.

Some women deliver at home not because they choose to, but out of circumstances like bad timing of labour especially when it starts at night or precipitated labour. This is worsened by poor road network.

There is also the convenience of accessing TBAs in the neighborhood and fear of so many examinations and procedures at the health facilities e.g suturing of tears and episiotomies after delivery in addition to the fear of a caesarian section.
5.4 Conclusions

The study concluded that: the socio-demographic factors such as age, marital status and education have statistical significant relationship with male partner involvement in promoting skilled attendance at childbirth. Married men are more likely to promote the use of skilled attendance by their partners unlike the unmarried men. Similarly, the more educated men promote the use of skilled care during childbirth.

Socio-cultural factors have significant contribution towards male partner involvement in promoting skilled attendance at childbirth. Religious convictions hinder the use and promotion of skilled attendance during delivery; this is due to the fact that some denominations do not allow the use of ‘science’ on their members.

Men who have already had a child and who help their wives at home more give more active assistance during labor and encourage the use of a skilled attendant during delivery. However, culturally in this area decision making lies entirely on the men.

It was also concluded that socio-economic factors do contribute a lot to male partner involvement in promoting skilled attendance at childbirth. The economic position (income level) poses a great influence on their choice of childbirth attendance. There is an observed association between income level and husband’s choice of childbirth attendance. Basically, women whose partners were of high-income level were mainly found in the hospital setting seeking skilled attendance while majority of those who go for unskilled attendance during delivery are of low-income level. Skilled attendance during delivery costs much more money than the unskilled attendance.

Safety during delivery determines the choice of the respective places or centers of childbirth including the kind of attendance one is to get. All mothers need skilled care at
delivery, without this care they either die or suffer long-term disease or disability. Non-cooperation care of providers in hospital settings make most clients seek the assistance from TBAs. This was in line with a study carried out in Tanzania that identified the non-cooperative and disrespectful attitudes of providers in hospital settings as the main reason that make most clients seek unskilled assistance. The TBAs attributed the continued demand for their services to the high quality and wide-ranging nature of these services, and to their sensitivity to their clientele’s needs, which contrasts with the abusive treatment many women receive in hospital settings.

5.5 Recommendations

The following recommendations are made based on the study findings and conclusions of this research:

1. Programs should be introduced to reach males as well as females, not only with information and services to protect themselves and their partners, but also with messages regarding gender equity. Programs are to be designed to serve men as RH clients in much the same fashion as programs have served women.

2. The government should channel programs to the grass-root levels to enable those in remote/rural areas access education on reproductive health and maternal health. At the same time it is important to equip the facilities as well as look into staffing matters as the skilled professionals are very few.

3. Men should also be freely allowed to accompany their partner to a facility in times of delivery. This will be of great benefit on their learning process to understand the need of skilled attendance at every delivery.
4. Improvement of infrastructure in the area would help a lot since it will enhance movement especially to the health facilities.

5. It is also necessary to train all birth attendants including the TBAs; this will help in providing skilled attendance even out of a health facility since the skilled attendants in most counties are few for the number of clients.

5.6 Suggestions for Further Studies

The study recommends the following areas for future studies: Since the study was carried out in rural set up, the researcher recommends that future study could be conducted in urban slums to compare and contrasts the findings. Finally, future research could be carried out to investigate women options on deliveries by TBAs instead of skilled professionals in the rural set up.
REFERENCES


Kenya Demographic and Health Survey (KDHS) (2014) The key indicators: carried out by the Kenya National Bureau of Statistics (KNBS) in partnership with the National AIDS Control Council (NACC), the Ministry of Health, the Kenya Medical Research Institute (KEMRI), and the National Council for Population and Development (NCPD).

Kenya Demographic and Health Survey (KDHS) (2008-09) carried out by the Kenya National Bureau of Statistics (KNBS) in partnership with the National AIDS Control Council (NACC), the National AIDS/STD Control Programme (NASCOP), the Ministry of Health and Sanitation, the Kenya Medical Research Institute (KEMRI), and the National Coordinating Agency for Population and Development (NCAPD).


APPENDIX 1: BUSIA DISTRICT MAP
APPENDIX 2: RESEARCH AUTHORIZATION

REPUBLIC OF KENYA

NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telegrams: “SCIENTECH”, Nairobi
Telephone: 254-020-241349, 2213102
254-020-310571, 2213123.
Fax: 254-020-2213215, 318245, 318249
When replying please quote

Our Ref: NCST/RCD/12A/012/29 1st March 2012

Roselilian Andanje
Kenyatta University
P.O.Box 43844-00100
Nairobi.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on “Male partner involvement in promoting skilled attendance at childbirth in Matayos Division, Busia County, Kenya,” I am pleased to inform you that you have been authorized to undertake research in Busia District for a period ending 31st April 2012.

You are advised to report to The District Commissioner, the District Education Officer and the Medical Officer of Health, Busia District before embarking on the research project.

On completion of the research, you are expected to submit two hard copies and one soft copy in pdf of the research report/thesis to our office.

DR. M. K. RUGUTT, PhD, HSC.
DEPUTY COUNCIL SECRETARY

Copy to:

The District Commissioner
The District Education Officer
The Medical Officer of Health
Busia District.
APPENDIX 3: CONSENT FORM

Written Consent Form

You are invited to participate in a research study conducted by Roselilian K. Andanje a Master student in the School of Public Health at Kenyatta University. I hope to learn on the involvement of male partners in promoting skilled attendance during childbirth in Matayos division.

If you decide to participate, you will be expected to respond to the questions in the questionnaire which will take not more than 20 minutes of your time. I anticipate that the study will be of benefit to our community however, I cannot guarantee that you personally will receive any benefits from this research.

Your responses to this study will be anonymous. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Your participation is voluntary. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time without penalty.

If you have any questions about the study, please feel free to contact the researcher on 0722653195, andanjero@gmail.com or my supervisors Dr. Keraka, on Tel +254 8710901 ext 3771 email: mnyanchoka2000@yahoo.com and Dr Okumbe, on gmokumbe@yahoo.com. You will be offered a copy of this form to keep.

CONSENT

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant's signature __________________ Date __________

Investigator's signature __________________ Date __________
APPENDIX 4: QUESTIONNAIRE (MALE PARTNERS MALE PARTNER INVOLVEMENT IN PROMOTING SKILLED ATTENDANCE DURING CHILDBIRTH IN MATAYOS)

Instructions: (Please read the instructions given and answer the questions as appropriately as possible). It is advisable that you answer or fill in each section as provided. Make an attempt to answer every question fully and correctly.

SECTION 1: BACKGROUND INFORMATION

1. Age
   a) below 25  b) 26-40  c) 41-55  d) over 55

2. Highest level of education
   a) None,   b) Primary   c) Secondary   d) College   e) University

3. Marital status:
   a) Single [ ]   b) Married [ ]   c) Divorced [ ]
   d) Widowed [ ]   e) Separated [ ]

4. Type of marriage
   a) Monogamy   b) Polygamy   c) any other

5. Employment status
   a) Employed [ ]   b) Self-employed [ ]   c) Any other

6. Number of children
   a) 1-2 [ ]   b) 3-4 [ ]   c) 5 and above [ ]

7. Attendance during delivery

<table>
<thead>
<tr>
<th>Question</th>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where was your last baby delivered? (which setting)</td>
<td>a. Health facility</td>
</tr>
<tr>
<td></td>
<td>b. Home</td>
</tr>
<tr>
<td></td>
<td>c. Other specify..............</td>
</tr>
</tbody>
</table>
| If your partner delivered at a health facility, who assisted your delivery? | a. SBA  
| | b. CHEW  
| | c. TBA  
| | d. Other specify  
| If she delivered at home, who assisted your delivery? | a. SBA  
| | b. TTBA  
| | c. CHEW  
| | d. TBA  
| | e. Close relatives/friends  
| | f. Other specify  
| Why did you choose to deliver with the above mentioned person? (probe for as many reasons as possible) |

### SECTION II Socio-Cultural Influence on Male Involvement in Childbirth

8. Did you accompany your partner to the health facility to receive maternal health care services during pregnancy period?  
   a) Yes [ ]  
   b) No [ ]

ii) If yes, how? .................................................................

iii) If No, why? ........................................................................

iv) What effect do you think your participation brought on your partner’s wellbeing?  
   a) Positive [ ]  
   b) Negative [ ]  
   c) No effect [ ]

9. Were you present during your last child’s delivery?  
   a) Yes [ ]  
   b) No [ ]

ii) If No, what was the reason of your absence? ........................................

   a) Not necessary  
   b) Job does not permit  
   c) Wife at parent’s house  
   d) Other reasons .................................................................
10. As a couple did you discuss and decide together on place of delivery?
   a) Yes [ ]  
   b) No [ ]

ii) If No, why not?..............................................................................................................................

11. Which religion do you practice?
   a. Protestant [ ]
   b. Islam [ ]
   c. Catholic [ ]
   d. Traditional African Religion [ ]
   e. Other specify……………………

ii) What religious beliefs may affect your choice of delivery assistance?
...........................................................................................................................................................

12. Does your community have any practices associated with delivery?
    a) Yes [ ]  
    b) No [ ]

ii) What are some of the traditional practices in your community associated with delivery?
    a. Use of traditional birthing position
    b. Pre and post-delivery massage
    c. Use of hot water after delivery
    d. Use of herbal medicine
    e. Don’t know
    f. Others specify……………………

iii) What are some of the cultural practices performed in your community during delivery? (List practices).........................................................................................................................
13. The following statements relate to socio-cultural influence on male involvement in childbirth. How much do you agree with them? Indicate the extent of agreement, by ticking appropriately. Use 1-no extent, 2-low extent, 3-moderate extent, 4-great extent, 5-very great extent.

| Men involvement is needed in order to improve maternal well-being | 1 | 2 | 3 | 4 | 5 |
| Having a skilled attendant at every delivery lead to marked reductions in maternal mortality |  |
| Involving both partners and encouraging couple joint decision making in maternal health provide an important strategy in achieving women’s empowerment |  |
| Fear of being tested for HIV hindered me from accompanying my wife to the clinic |  |

**Section III Influence of Health Care Facility on Male Involvement in Childbirth**

14. Is there a health care facility in your area?  
   a) Yes [ ]  
   b) No [ ]

ii) If yes, what kind of a facility is it?  
   a) Health Centre [ ]  
   b) Dispensary [ ]
   c) Private clinic [ ]  
   d) Dispensing Chemist [ ]

15. What is the distance from your house to the nearest health care facility in your area?  
   a) 0-1 km [ ]  
   b) 1-2 km [ ]  
   c) 3 km and above [ ]

16. What is the attitude of the health care providers towards patients at the health facility?  
   a) Negative [ ]  
   b) Positive [ ]  
   c) Neutral [ ]
17. What is your opinion on the statement that “Most of the Mothers in Matayo’s are delivered by untrained workers called traditional birth attendants”?
   a) True [  ]          b) Untrue [  ]          c) Not sure [  ]

18. How do you rate the costs involved with use of Health care facilities?
   a) High [  ]          b) Moderate [  ]          c) Low [  ]

19. Did the awareness of the existence of the childbirth setting (in a hospital or by a TBA) influence the selection of where your child was born in?
   a) Yes [  ]          b) No [  ]

20. To what extent do you agree with the following statements on health care facility and male involvement in childbirth? Please use 1-strongly disagree, 2-disagree, 3-not sure, 4-agree, 5-strongly agree.

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<tr>
<th></th>
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<th>2</th>
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<tbody>
<tr>
<td>Most of the mothers in Matayos are delivered by untrained</td>
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<tr>
<td>workers called traditional birth attendants</td>
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<td>well-equipped facilities are available at the health facilities</td>
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<tr>
<td>The attitude of the health care providers discourages husbands</td>
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<td>to participate in seeking skilled attendance during delivery.</td>
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<tr>
<td>Non-cooperation care of providers in hospital settings make</td>
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<td>most clients seek their assistance from TBAs</td>
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<td>TBAs are sensitive to their clientele's needs thus the</td>
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<td>continued demand for their services</td>
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<td>Long waiting time at the health facility</td>
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</table>
Section V Influence of socio-economic and Demographics on male partner involvement in promoting deliveries by skilled professionals.

21. What is your average family income per month?
   
a) Less than KSh.1000
b. KSh. 1,001-5,000
c. KSh. 5,001-10,000
d. Above KSh. 10,000

22. Did the economic position of your family influence the choice of childbirth setting?
   
a) Yes [   ]  
b) No [   ]

23. How much do you agree with the statement that, “men of high-income level go for hospital delivery while majority of those who go for out-of hospital delivery are of low-income level?”
   a) Strongly disagree [   ]  
b) Disagree [   ]  
c) Not sure [   ]  
d) Agree [   ]  
e) Strongly agree [   ]

24. To which extent did each of the following issues impact on your choice to prepare for childbirth? Use 1-no extent, 2-low extent, 3-moderate extent, 4-great extent, 5-very great extent

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<tbody>
<tr>
<td>Social class</td>
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<tr>
<td>Religion</td>
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<tr>
<td>Husband-wife relationship</td>
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</table>

25. Does the education status influence the selection of childbirth attendance?
   
a) Yes [   ]  
b) No [   ]
26. How much do you agree with the following statements on demographic influence on male attendance in childbirth? Use the scale where 1-strongly disagree, 2-disagree, 3-not sure, 4-agree, 5-strongly agree

<table>
<thead>
<tr>
<th>Statement</th>
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<tbody>
<tr>
<td>Male partner’s willingness to participate in childbirth brings physical comfort and satisfaction of his wife</td>
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<tr>
<td>Male involvement during labor is influenced by whether the husband prepared for birth.</td>
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<tr>
<td>Men who have already had a child give more active assistance during labor</td>
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<tr>
<td>Men who were knowledgeable of skilled attendants services are likely promote it</td>
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<tr>
<td>Educated women have more contributory power in reproductive matters within the family</td>
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**Section V Perceived fear of complications on male partner involvement in promoting deliveries by skilled professionals**

27. Do you know of maternal related deaths in this area over the last 3 years?
   a) Yes [ ]  
   b) No [ ]

ii) What is the trend?
   a) Very low [ ]  
   b) low [ ]  
   c) moderate [ ]  
   d) high [ ]  
   e) very high [ ]

28. Does the safety during delivery determine the choice of the respective places or centers of childbirth?  
   a) Yes [ ]  
   b) No [ ]
29. In your own view, are the facilities available for childbirth well equipped to cater for any complications during delivery?  a) Yes [ ]  b) No [ ]

30. How much do you agree with the statement that” Safety during delivery determine the choice of the respective places or centers of childbirth”?  
   a) 1-strongly disagree [ ]  b) 2-disagree [ ]  c) 3-not sure [ ]  
   d) 4-agree [ ]  e) 5-strongly agree [ ]

31. Did perceived fear of complications lead your choice of place of delivery and choice of assistance during delivery?  a) Yes [ ]  B) No [ ]

32. Between deliveries by TBAs and deliveries by skilled professionals where is the Perceived fear of complications greatest?  
   a) TBAs  b) Skilled professionals  c) Others

33. To what extend do you agree with the following statements on Knowledge of complications during childbirth? Use the scale where 1-strongly disagree, 2-disagree, 3-not sure, 4-agree, 5-strongly agree

<table>
<thead>
<tr>
<th>Statement</th>
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<th>2</th>
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<tbody>
<tr>
<td>Excessive bleeding(PPH) is a danger sign during delivery</td>
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<tr>
<td>Retained placenta is a danger sign during delivery</td>
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<tr>
<td>Obstructed labour/prolonged labour is a danger during delivery</td>
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<tr>
<td>Abnormal fetal positioning is a danger sign during delivery</td>
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<tr>
<td>Code around the child&quot;s neck is a danger sign during delivery</td>
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THANK YOU FOR YOUR TIME AND PARTICIPATION
APPENDIX 5: FOCUS GROUP DISCUSSION GUIDE
MALE PARTNER INVOLVEMENT IN PROMOTING SKILLED
ATTENDANCE DURING CHILDBIRTH IN MATAYOS

Instructions: (Please read the instructions given and answer the questions as appropriately as possible). It is advisable that you answer or fill in each section as provided. Make an attempt to answer every question fully and correctly.

SECTION I Socio-Cultural Influence on Male Attendance in Childbirth

1. What do you understand by the term skilled attendance during delivery?
   ……………………………………………………………………………………………

2. Has having a skilled attendant at every delivery lead to marked reductions in maternal death?
   Please explain ………………………………………………………………………

3. What do you think about men involvement in promoting the use of skilled attendance in Matayos Sub-county ………………………………………………………………………

4. Does involving both partners and encouraging couple joint decision making in maternal health provide an important strategy in achieving women’s empowerment
   Kindly give reasons ………………………………………………………………………

5. Do male partners accompany their partners to the health facility to receive maternal health care services during pregnancy period?
   Give reasons ……………………………………………………………………………

6. What about when going for delivery…………………………………………

7. Are men tested for HIV when they accompanying their female partners to clinic?
   Give details ……………………………………………………………………………
8. How does availability of health care facilities in your area affect male involvement in childbirth? Kindly explain………………………………………………………………………

10. Does Attitude of the health care providers discourage male partners to participate in seeking maternal health care at the health facilities? Please give reasons…………………………………………………………………………………..

11. Do you think TBAs are sensitive to their clientele's needs thus the continued demand for their services. Explain ………………………………………………………………

12. Is male involvement during labor influenced by whether the male partner was prepared for birth or not? Explain ……………………………………………………………………………………..

13. Are men who are knowledgeable of maternal health care services likely to accompany their spouses at delivery? ………………………………………………………………..
Give a reasons for your answer …………………………………………………………………………

14. In your opinion, do educated men have more contributory power in reproductive matters within the family? Explain ………………………………………………………………..

15. How much do you agree with the statement that” Safety during delivery determine the choice of the respective places or centers of childbirth”? Give a reason ………………………………………………………………………………………………..

16. Between deliveries by TBAs and deliveries by skilled professionals where is the Perceived fear of complications greatest?  
   a) TBAs  b) Skilled professionals  c) Others  
   Explain further……………………………………………………………………………………………..

THANK YOU FOR YOUR TIME AND PARTICIPATION