LEVELS OF KNOWLEDGE, ATTITUDE AND PRACTICE OF ANTE NATAL CARE ATTENDING MOTHERS ON SAFE MOTHERHOOD

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Abstract

Purpose: The main purpose of this study was to establish the levels of knowledge, attitude and practice of ante natal care attending mothers on safe motherhood among communities of Kwale and Kilifi Counties of Coastal Kenya.

Methodology: The study was descriptive cross sectional design. The study focused on women of child-bearing age 15 – 49 and men aged 15 – 54 from Kilifi and Kwale counties in 14 health facilities. Qualitative and quantitative methods of data collection were used. Interviewer-administered questionnaire were administered to women who were attending ANC. Data was also collected using semi-structured interviews with health service providers, community leaders and county directors. Focus group discussions were conducted using FGD guide with four women and men groups. Analysis was done using SPSS and NVivo softwares.

Results: The findings revealed that generally the number of women accompanied by their partners for ANC is low at only 20.6% (80). Similar to this is a study by Awasthi *et al.*, (2008) from India which indicated that only 18.33% of male partner were present during antenatal check-ups. Additionally in a related study only by Carter *et al*, (2002) 19.7% of women were accompanied by their male partners during current visit. Overall, men's company and physical support of women to seek antenatal and delivery care was merited by most respondents but mostly inhibited by a number beliefs and practices attached to pregnancy and birth in these communities.

Policy recommendation: The study recommends a defined program that target male involvement strategy. It will involve male champions/men ambassador/agents being supported to go to the *Mnazi* dens and educate, sensitize and support dialogues with men aged 35 years and

below. A friendly health system be put in place to accommodate men. Friendlier timing including weekends and late hours, space at the clinics to accommodate men and responsive health workers.

Keywords: *Knowledge, Attitude and Practice Safe Motherhood Practices and Male Involvement*

INTRODUCTION

Service related factors are more important than user related factors in affecting male involvement in maternal health care services. The most important ones pointed out include, long physical distance from the health unit, lack of transportation, inconvenient clinic hours, long waiting time at the clinic, poor technical and interpersonal skills. The situation is worsened by the fact that information received from health workers on maternal health care is primarily aimed at women as was reported by (UNFPA 1999) in several developing countries that women not men were the targets of reproductive health programmes yet most of them are not financially or culturally positioned to make decisions about these issues without consulting their husbands. This may actively discourage men from participating in maternal health care services by the structure of services or by attitudes of health care workers.

Majority of health care workers are women in the Kenyan healthcare service delivery with the two rural study counties having a high number. Men are therefore not inclined to visit the facilities as they deem to have very little to help the women. This is complicated by the perception that safe motherhood is a women domain hence more women service providers. In the Muslim community of Kwale most men do not allow their wives to be examined by men which underpin the misconception associated by men in the delivery of safe motherhood services. Family planning for example has suffered a significance blow due to men attitude. Most men believe its against the religion and therefore deter their wives from utilization. This has been supported by studies in India by (Shattuck *et al.* 2011**)** which found that spousal disagreement can be a deterrent to use of FP, as women may fear initiating a difficult conversation about FP. Additionally, male attitudes towards FP was found to affect contraceptive use indirectly. Specifically the absence of explicit communication was attributed to women incorrectly perceiving that their partners being opposed to FP and therefore use contraception without telling their partners or don't use contraception at all. In the coastal region of Kenya most men report no intention to use FP in the future citing major reasons as wanting to have a child and feeling that FP was against their religion.

According to Rosliza and Muhamad (2011) the maternal health status of Orang Asli women in Malaysia was noted to be lower as compared to other groups of population in the country. This study aimed to determine the level of knowledge, attitude and practice on antenatal care, which is a vital component of maternal health among the Orang Asli women in three Orang Asli villages in Jempol District, Negeri Sembilan. All women aged between 15 to 49 years old who had at least one antenatal experience were interviewed using a structured, pretested

questionnaire. A total of 104 women were interviewed. Among them, 92.3% admitted attending antenatal clinic during their previous pregnancies while only 48.1% came early for their first check-up. About 70% of the women had history of home delivery and 44.2% had experienced at least one high risk pregnancy before. Study revealed that 44.2% (95% CI, 34.7 – 53.7%) of the women have good knowledge regarding antenatal care while 53.8% (95% CI, 44.3 – 63.1%) of them noted to have positive attitude regarding antenatal care. However, result showed that the level of knowledge regarding the importance of early antenatal care, screening test and complications of diabetes and hypertension in pregnancy were poor. In conclusion, the rate of home delivery and late antenatal booking was still high among the Orang Asli women and it is significantly associated with their attitude regarding antenatal care. These findings can be used to plan a customized health intervention program aiming to improve the maternal health practices and eventually improve the health status of the Orang Asli women.

According to Patel (2015) the maternal health status of Indian women was noted to be lower as compared to other developed countries. Promotion of maternal and child health has been one of the most important components of the Family Welfare Programme of the Government of India. For sustainable growth and development of country, there is a need to improve MCH Care in the country. Safe motherhood by providing good antenatal care (ANC) is very important to reduce maternal mortality ratio and infant mortality rate and to achieve millennium development goals. This study aimed to determine the level of knowledge, attitude, and practice on ANC among pregnant women attending the antenatal clinic at a Tertiary Care Hospital in Pune and their association with various sociodemographic factors. A cross-sectional study was carried out among 384 pregnant women in their 3rd trimester attending the antenatal clinic in a Tertiary Care Hospital of Pune, Maharashtra during October 2011 to September 2012. Pretested questionnaire was used for collecting data by interview after obtaining informed consent. Statistical analysis was performed using SPSS version 20 and Epi Info Software. Results: Study reveals that about 58% women had adequate knowledge regarding ANC. It was found that almost all the variables such as age, education, occupation, parity, type of family, and socioeconomic status (SES) had a significant association with awareness about ANC. 100% women were having a positive attitude toward ANC. Around 70%, women were practicing adequately, and variables such as education and SES had a significant association with practices about ANC. Conclusion: These Findings can be used to plan a Health Intervention Program aiming to improve the maternal health practices and eventually improve the health status of the women.

1.2 Problem statement

Male involvement is often and traditionally poorly understood and too narrowly defined. Minimal attention has been given to their important role in decision-making within the family and community context. Barriers such as low levels of education, the lack of available social support, the perception that pregnancy and child-bearing are “women’s responsibilities”, and prevailing gender norms and societal stigma persist. Moreover, the concept of male involvement cannot be viewed only through the lens of sexual and reproductive health; it must extend to the broader context – including economic empowerment, financial decision-making within the household, nutrition to education.

The role played by men and their relationship with women in reproductive health has been appreciated by many and even documented. There is absolutely little excuse for overlooking men in this regard. Ten years ago, the 1994 United Nations International Conference on Population

and Development (ICPD) stressed "male responsibilities and participation" in sexual and reproductive health. In fact Dudgeon *et al*. confirms that for several decades, medical anthropologists have conducted reproductive health research that explores male partners' effects on women's health and the health of children.

Although there are more considerations for male involvement strategies in the current programming in sub Saharan Africa, the lack of data on successes has limited the replication and further investment in this intervention. In a documentary by FAO, the technical o*ccasional* Paper Series No. 1 June 1998, sites the lack of data to understand male perspectives and the extent of their involvement in reproductive health issues as a major setback. It presupposes that the surveys most relied upon for reproductive health (RH) programmes usually ask questions only of women, assuming that they are the ones who make the decisions regarding reproduction and that the men are either not involved or marginally involved. This is why this study will deliberately target men in male unions and groups to try and provide opportunity of fair participation.

Men are traditionally the decision-makers within Kenyan households, and women's access to and use of sexual and reproductive health services often depends upon their partner's knowledge and decisions. Commonly referred to as *"mwenye syndrome"* in the coastal region meaning men own women and hence all the decisions depend on them including accessing safe motherhood services. Men play crucial role in contraceptive decision-making, particularly in highly gender-stratified populations like in the coastal region.

Research suggests that male involvement can increase uptake and continuation of family planning methods and by extension safe motherhood services by improving spousal communication (Awah 2002**)** through pathways of increased knowledge or decreased male opposition. The need to understand barriers to male involvement and participation and whether there are any association with access to services and health seeking behaviors towards safe motherhood is crucial. This study will therefore determine the factors that influence male involvement in safe motherhood among communities in Kwale and Kilifi counties of coastal Kenya.

2.0 METHODOLOGY

The study was carried out in two counties; Kilifi and Kwale counties of coastal Kenya. The populations in these counties are primarily with low levels of education and poor, hence compromising their health service utilization. The study was descriptive cross sectional. The study focused on women of child-bearing age 15 – 49 and men aged 15 – 54 from Kilifi and Kwale counties in 14 health facilities. Specifically the study conveniently recruited 22 male of 18 years of age and above, and 66 pregnant women and mothers 18 years or older attending ANC and were either accompanied by their partners, had delivered at the hospital or attending postnatal care services, and had cconsented to participate. Qualitative and quantitative methods of data collection were used. Interviewer-administered questionnaire were administered to women who were attending ANC. Data was also collected using semi-structured interviews with health service providers, community leaders and county directors. Focus group discussions were conducted using FGD guide with four women and men groups. Analysis was done using SPSS and NVivo softwares.

3.0 RESULTS FINDINGS

3.1 Levels of knowledge, attitude and practice of ante natal care attending mothers on safe motherhood

Generally knowledge on safe motherhood was wide with 91% seeking permission for antenatal clinic attendance and 90% having attended antenatal care during the previous pregnancy and after discussion with spouse. Out of 366 women interviewed, 39.6% (145) discussed preparation for the baby while 28.4% (104) discussed where to attend ANC and deliver and why. This is confirmed by the respondent in FGDs and KII who emphasized that SM is: services to mothers for safety and wellness; better life for children; mothers being safe and happy; care of the baby and ANC; period between ANC, delivery, PNC; It's also the journey of a woman and a man during pregnancy. They argued it starts from adolescent- pregnancy -ANC - delivery and post-natal care up to 28 weeks. These definitions are reflected in the spousal discussion during pregnancy. It's clear that most women were knowledgeable about their roles during pregnancy and engaged men in discussion and decision making in various components of safe motherhood.

During the FGDs, community health volunteers and male union members reported a basic knowledge of safe motherhood as encompassing women preparing to give birth for nine months. Health during pregnancy was regarded as a key element of safe motherhood. Interestingly though pregnancy and its outcome are keenly the interest of the entire household with husbands, mothers and mother in law being very involved in the process. A pregnant woman delivering in the facility was seen as the safest means available and well appreciated by the various families and interest parties. However, most women preferred to deliver at home with the help of traditional birth attendants. This is confirmed by the low number of women (28.4%) who discussed where to deliver. The spouses, husbands and mother in laws all agree on the importance of self-care before pregnancy; traditionally it was translated to mean a woman is legally married.

There was evidence of women knowledge in the benefits of being accompanied to the ANC. Most believed that those accompanied tend to benefit from knowing HIV status, knowledge of ANC and health. Most men were busy looking for food and money to support their families so had no choice but to prioritize confirming the finding that 94.8% were engaged in livelihood activities. . Traditionally the communities did not object to cross generational marriages and in this particular study old men married young girls and unable to be seen with them publicly. This similar to the finding from interview with women whom 93.5% were married and this included age groups of between 15-20 and 21-25 years. Although there are benefits of being accompanied to the facility, the idea had not been embraced and only 20.6%were accompanied to the health facility.

Practices

Majority 97.8% of women who had previous pregnancy attended ANC. The strong feeling of women to seek permission from their husbands to attend antenatal clinic was a clear evidence of male dominance in decision making compared to 91% who sort permission to attend ANC. According to most respondents men/ husbands were traditionally the decision makers and their decisions were not subject to any discussions. In the study this is described as "Mwenye Syndrome" which basically means that the man is the owner of all the property including their women and children and that they are the ultimate decision makers. This finding is confirmed by respondents who confirmed that 75.9% husbands were to be told first about the pregnancy.

> *"The Mwenye syndrome, so men just give instruction, ignorance, they are not involved by women. Women are more knowledgeable so they feel inferior"* (Chief, female, Kilifi)

Early marriages also came out as an issue affecting safe motherhood. Some women are married very young (approx. 14%) and have no idea about safe motherhood or because of shame they are hiding from everybody. Stigma and discrimination especially for under age marriages is associated with high disability are high because women do not to come out of their hiding leading to birth complications and largely home deliveries. Early marriages in both counties was the norm and it was due to the high teenage pregnancy hence being perceived as a solution.

Sometimes men thought their women were unfaithful when they have to go the hospital frequently hence most women wait until later in the pregnancy. Geographical access to facilities was also reported as a challenge in some areas and this deters women attending the regular ANC appointments but rather value mainly the first visit which was attached to an opportunity to get ANC profile done and baby-mother booklet issued. Moreover women reported that they fear the frequency they have to attend ANC as a result therefore they wait until they feel the fetus is playing in the tummy. They argued that if they went early the doctor won't feel anything. Women would like to lessen the frequency to the facility, but also some are not sure on action to take as they are too young or on FP and therefore delay going to the facility and does not discuss the same with men. Amenorrhea for those on long acting FP make women ignorant of their pregnancy status.

Ignorance was reported for both for men and women particularly not being sure of being pregnant because of not having periods and lack information on FP which led to many women getting pregnant without knowing. For instance, a woman reported to have gotten pregnant of the second one when the first child was only four months but fears of being examined in the uterus deterred her from going for ANC.

Our findings also show that Health service providers often are not available at the dispensary. Staff shortage therefore was a deterrent factor for men's involvement in safe motherhood practices. Most men however were reported to be cowards as they feared they might be tested for HIV hence did not accompany their spouses to ANC.

> *TBAs are the main health service providers. Facilities are run by women and men don't bow to women.* (Village elder, male Kilifi)

Beliefs and taboos surrounding placenta disposal that it must be at home and it's a tradition for women to deliver at home contributed to ANC apathy. Most women preferred to wait until they have a complication to visit health facilities.

Health Service Providers educate mothers for clinic revisits, create awareness and need to seek health services. In other instances, Community Health Volunteers' advice on health seeking behaviors through sensitization, education and counseling during home visits. This study found out that infrastructure, attitude of human resource and distance to facility was an issue for men. The timing and a high number of women service providers was a barrier for men to be involved in safe motherhood practices. As one man noted:

> *"Most service providers are women and look at men differently. Most facilities have so many women and no space for men. The booklet for baby mother excludes men even in the parenting process. The ANC clinic for example is full of women. Working hours for*

facilities close do not allow men to be involved". (Male participant from men unions, Kwale)

5.0 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of Findings

The findings revealed that generally the number of women accompanied by their partners for ANC is low at only 20.6% (80). Similar to this is a study by Awasthi *et al.*, (2008) from India which indicated that only 18.33% of male partner were present during antenatal check-ups. Additionally in a related study only by Carter *et al*, (2002) 19.7% of women were accompanied by their male partners during current visit. Overall, men's company and physical support of women to seek antenatal and delivery care was merited by most respondents but mostly inhibited by a number beliefs and practices attached to pregnancy and birth in these communities.

5.2 Conclusion

The study concluded that Women were more knowledgeable of safe motherhood matters and initiated discussions with their husbands. Maternal nutrition was however passively discussed yet a very important issue and warrants further investigation. Additionally the study reveals which women do not attend ANC.

5.3 Recommendations of the Study

The study recommends a defined program that target male involvement strategy. It will involve male champions/men ambassador/agents being supported to go to the *Mnazi* dens and educate, sensitize and support dialogues with men aged 35 years and below. A friendly health system be put in place to accommodate men. Friendlier timing including weekends and late hours, space at the clinics to accommodate men and responsive health workers.

Declarations

Ethics approval and consent to participate

Ethical approval was sort by the researcher and provided by Pwani University Ethics Review Committee (REFERENCE NO: ERC/MSc/040/2014) (Annex 5) and additional formal permissions obtained from the office of the Chief Officer of health Kwale county Ref no: CG/KWL/6/5/1//COH/44/12 (Annex 3) and Director of Health Kilifi County. Further, the researcher obtained authorization and ethical approval from the study supervisor and the local Research Ethics Coordinator of the academic unit at the university. To gain access to the participants and study approval, both local and national permission were sought formally and received from the County and Sub County Health Management Team. Further, the Community Strategy technical support staff from DSW project working in the county were contacted to link the researcher with the target participants as they closely work with them.

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