SOCIO-ECONOMIC AND SOCIO-DEMOGRAPHIC CHARACTERISTICS OF WOMEN ATTENDING ANTE NATAL CARE SERVICES

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Abstract

Purpose: The main purpose of this study was to establish the effect of social economic and socio demographics characteristics influencing male involvement in 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 majority of women were not accompanied by their spouses to the facilities for safe motherhood services. It emerged that most of the couples wanted children even for those aged 15-20 years. Over 90% of respondents were married which is an indication of high rate of teenage pregnancy, early sexual debut and high rate of marriage before age of 20years. This could have been explained by the need to maximize on childbearing and the cultural fit syndrome particularly for the tradition of son- male children to carry the family mantle.

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. Also the study recommends that as poverty is an issue initiate Income generating

activities both for men and women. Develop a work place program to net as many men as possible.

Keywords: *Social Economic and Demographics, Safe Motherhood Practices and Male Involvement*

INTRODUCTION

Educated people are more likely to listen to radio than the non-educated persons hence getting more information about family planning. With the new government policy of universal primary education and the universal secondary education in the pipeline will go a long way to eradicating this barrier. It's a known fact that illiteracy or low education is associated with many risks (KAIS 2007). This study also found that people with low education are unlikely to embrace the modern ways of safe motherhood. For example many women prefer TBAs that skilled facility delivery (KDHS, 2008/9). The ICPD 1994, recommended a focus to education for women to ensure they meet the basic human needs and ensure they exercise their rights. This underpins the necessity of education when it comes to access safe motherhood services, which is considered a right.

Several studies have shown that socio-demographic factors affect the utilisation of maternal health care services (Celic & Hotchkiss 2000; Mekonnen & Mekonnen 2003; Woldemicael & Tenkorang 2009). Below we review the empirical evidence of the selected socio-demographic factors that affect the utilisation of maternal health care services. Even though previous studies have observed that age influences maternal health care services in developing countries (Mengistu and James 1996), there is no consensus on the direction of influence. On the one hand, scholars such as Okutu (2011) argue that younger (aged less than 20years) and middle aged mothers (aged 20-34years) are more likely to seek pregnancy-related care services from skilled attendants compared to mothers aged 34 and above years in Uganda.

Vallieres et al. (2013) found a significant difference in skilled birth attendance between heads of households in Uganda with some primary education and heads of household with some secondary education or higher whereby those with secondary or higher education were significantly more likely to seek a skilled birth attendant. The difference in health centre delivery between heads of household with a primary education and heads of household with a secondary or higher education was also significant; those with secondary or higher education were significantly more likely to deliver in a health facility. Education empowers women in terms of not only knowledge about the availability and benefits of maternal health services but also the autonomy to make independent decisions about their health. In view of this, we expect women who are educated to make more frequent use of maternal health care services compared to those who are not educated. These patterns are consistent with those observed with respect to other reproductive health services, such as contraceptive use.

Socio-economic factors responsible for poor utilization of primary health care services in rural community in Nigeria, Katun (2001), discovered that low economic status of community

members coupled with the lack of social security, welfare and health insurance system have deteriorating effects and further widens up the social gradient on choice of health provider. Though social structures and conditions, norms and values can limit the influences of people on what is possible, yet individuals act healthily in a wholly voluntary manner when they are empowered (Blaxter, 2004). Achieving empowerment is closely connected to addressing the root causes of disempowerment and tackling disadvantage caused by the way in which power relations shape choices, opportunities and wellbeing of vulnerable people. Hence, there is the need to empower people to acquire a degree of power and control in making wider choices (Tones and Green, 2004).

Some men feel it is a duty to facilitate their wives in terms of transport and if they do not have means of transport they see no point in escorting them while both are walking. Yet in many situations in Africa where the man is economically in position to provide the basic necessities of life he tends to have more than one wife, which also negatively affects his willingness and ability to escort the wife to seek care. Multiple partner relationships promotes different interests for the man and his partners and this will hamper possibilities for transparent decision making on maternal health service issues in addition to involvement in maternal health services of all his wives when needed. Reporting his findings (Ratcliffe 2001) noted that men are often involved in multiple sexual relationships that present a considerable challenge to fertility awareness and reproductive health programmes. Alcohol consumption by the men has also been noted to plays an important role in keeping men away from involvement in safe motherhood services as most of the time they may be drunk, leaving them with no money or time to facilitate the needed care.

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 Socio-economic and socio-demographic characteristics of women attending ante natal care services

Socio-demographic characteristics of the study participants drawn from the mothers attending ANC. Majority of the mothers (33.8 %) were aged between 21 and 25 years, 28.8% aged between 26 and 30 years with average age of 30 years. 17.2% were aged between 15 and 20 years. A bigger proportion (40.8 %) of the respondents belonged to the Digo ethnic group while 60.8 % were Muslims compared to 37.5% from the Christian affiliated religious denominations. 184(54.9 %) of the respondents had attained senior primary level of education with only 78(23.3%) attaining secondary primary level of education. A big percentage of the mothers (93.5%) were married with only 3.8% being single and 2% separated from their spouses (Table 1 below shows the characteristics of women attending ANC)

Table 1: Characteristics of women attending ANC study participants

Characteristics	Women attending ANC N=400 N (%)
Age (Years)	
15-20	70(17.5)
21-25	135(33.8)
26-30	115(28.8)
31-35	57(14.4)
36+	23(5.8)
Marital Status	
Married	372(93.5)
Single	15(3.8)
Separated	9(2.3)
Widowed	2(0.5)
Education	
Junior primary	46(13.7)
Senior primary	184(54.9)
Secondary	78(23.3)
Tertiary	27(8.1)
Means of Livelihood	
Business	103(25.8)
Piece work	118(29.5)
Office work	26(6.5)
Farming	42(10.5)
Others	111(27.8)
Religion	
Christians	147(37.6)
Muslims	237(60.6)
No Religion	7(1.8)

For the male partners accompanying their partners to health facilities for Safe Motherhood services most of them were reported to have low education levels. 93.4% were married considering that the same percentage of women interviewed was married. 49.1% of male partners (husbands) were doing piecework while 23% engaged in businesses. Majority (53%) of male partners who did piecework had at least one child. They also scored the highest (5%) for category of having more than 4 children. Table 2 below summarizes male study participants' characteristics.

Table 2: Husband's Livelihood * No. of deliveries Cross tabulation

		No. of deliveries						
		None	One	Two	Three	Four	More than four	Total
Husband's	Business	13	30	16	15	4	9	87

Livelihood	Piece work	24	49	45	28	19	21	186
	Office work	8	25	13	12	3	5	66
	Farming	0	2	5	4	8	9	28
	Other (specify)	2	5	1	1	1	2	12
Total		47	111	80	60	35	46	379

Religion

For Muslim women, there were perceptions that going for ANC would facilitate women being introduced to family planning use yet it was against their religion. Interestingly however, FP and other services use such as HIV were particularly low in Kilifi County. There were more Muslim women (56%) attending ANC than Christians (35%) and more so in Kwale than in Kilifi and as seen in figure 4.6.1 below, Muslim household appear to more resources to spend in health compared to the Christians. Moreover, religion also impacted greatly on men accompanying their spouses to the ANC and as one FGD participant observed:

> *For Muslims pregnancy is a woman's responsibility, men are not supposed to interact with other women, men are not supposed to see half naked women that's why they don't go to the maternity. For Christians men are supportive, considerate and some go to the clinic with their wives.* (Male religious leader, Kwale)

Table 3: Religion or denomination * Attendance to Antenatal care-previous pregnancy

			Attendance to Antenatal care-previous pregnancy		
			Yes	No	Total
Religion or denomination	Christian	Count	137	10	147
		% within Religion or denomination	93.2%	6.8%	100.0%
		% of Total	35.0%	2.6%	37.6%
	Muslim	Count	220	17	237
		% within Religion or denomination	92.8%	7.2%	100.0%
		% of Total	56.3%	4.3%	60.6%
	No religion	Count	6	1	7
		% within Religion or denomination	85.7%	14.3%	100.0%
		% of Total	1.5%	.3%	1.8%
Total		Count	363	28	391
		% within Religion or denomination	92.8%	7.2%	100.0%
		% of Total	92.8%	7.2%	100.0%

Attitude

Men perceive pregnancy is women thing and have their mothers supporting. The role of men was perceived to facilitating their women with transport as part of their involvement in safe motherhood as confirmed by their engagement in looking for money. Pregnancy was considered the responsibility of women and men perceived themselves as mere providers as one community health extension worker noted:

> *"Mostly pregnancy is a woman thing and the mothers both in law and mother have the responsibility to support as men look for the finances"* (CHEW, female, Kwale)

The feeling is that men should not walk with their wives as it's a sign that they are under their wives and this contributed to men's 'absence' during the pregnancy processes that were required of them. Generally, pregnancy, delivery and newborn care was seen as merely for the mother. Men queuing with women was reported as unacceptable thus in hospitals its women who are the majority. Men were said to be more involved when the baby start going to the clinic.

Education

Many men in the village were reported to be illiterate and less informed. They could not read even information from the materials that women took home. Inadequate or lack of education therefore came out as a major hindrance although some community members on the contrary reported education did not have any bearing in male involvement.

> "*Low education levels mean men do not understand many things are less exposed to current medical interventions*" (Village Elder, Male Kwale)

Economic

Most women considered themselves lower middle income level in Kilifi while their counter parts in Kwale consider themselves middle income level. Generally 39% (156) women perceived themselves as middle income level. There was a clear investment in health as indicated in the amount spent on health during the month. Most families (55%) spent at least Ksh 500 on a monthly basis on health while those on the low middle level income spent at least Ksh. 200 per month. Most husbands were the bread winners of their families and majorly generated their income from farming, wages/salaries and other forms of sources. Its men's responsibility to finance all the Expenditures. Most of the time they are away from home and delegate women to take care of the children. Poverty is a major issue that only allow families to plan resources for food and education and only some resource is left for health.

> *"Men are always in the Mnazi dens and also looking for money. Work related responsibilities makes men unavailable to offer support. Men are always out to get money and wait for the child to be born. Men are busy looking for work. Transport only available for women"*. (Women group leader, Kilifi)

Table 4: Monthly cost of health expenditures

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-500	190	47.5	55.2	55.2
	501-1000	58	14.5	16.9	72.1
	1001-3000	66	16.5	19.2	91.3

	3001-6000	21	5.3	6.1	97.4
	6001-9000	5	1.3	1.5	98.8
	9001-12000	3	.8	.9	99.7
	12001-15000	1	.3	.3	100.0
	Total	344	86.0	100.0	
Missing	System	56	14.0		
Total		400	100.0		

Table 5: Average monthly income of the household

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-1000	74	18.5	21.4	21.4
	1001-5000	119	29.8	34.4	55.8
	5001-10000	104	26.0	30.1	85.8
	10001-15000	27	6.8	7.8	93.6
	15001-20000	16	4.0	4.6	98.3
	above 20000	6	1.5	1.7	100.0
	Total	346	86.5	100.0	
Missing	System	54	13.5		
Total		400	100.0		

5.0 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of Findings

In this study conducted using a representative sample of women and men of reproductive age attending ANC in two counties of Kwale and Kilifi, majority of women were not accompanied by their spouses to the facilities for safe motherhood services. It emerged that most of the couples wanted children even for those aged 15-20 years. Over 90% of respondents were married which is an indication of high rate of teenage pregnancy, early sexual debut and high rate of marriage before age of 20years. This could have been explained by the need to maximize on childbearing and the cultural fit syndrome particularly for the tradition of son- male children to carry the family mantle. There was a general notion that children bore economic value as they would support in the family economic generation and marriage dowry. Some women are married very young (approx. 14%) hence stigma and discrimination for under age marriage which in turn makes women not to come out of their hiding leading to birth complications and largely home deliveries. They however reported a number of benefits for being accompanied by husband to the health facilities. The health system and service delivery efforts has been shown to be a fundamental determinant to attend or not to attend ANC for men and overall for women. This study found out that most providers are women and men found it difficult to be attended by

women service providers. Moreover, the lack of space and unfriendly timing for service hours (facility working hours) was also reported to be hindrance to male involvement in safe motherhood. The finding are supported by a study conducted by Byamugisha, and others (2010) in Mbale District in the Eastern Uganda who cited similar health system barriers to male involvement which included the structural set up of antenatal clinic and health workers not being client-friendly. This is further confirmed by a Reece *et al*. (2010) who conducted a study in Western Kenya to examine the reason for men noninvolvement in PMTCT initiative and other HIV–related services and found that health system barriers including low quality couple counselling, inflexible weekend clinic hours and clinic not being male-friendly were barriers to male involvement in safe motherhood.

5.2 Conclusion

Income was perhaps the most challenging for men as poverty levels were high and the cost of transport was only enough for the pregnant mother. Men were generally illiterate and poor as their households were rated as low income level. Farming and peace work were the major livelihood activities and generated less enough for health investment. Most women were married at an early age, a pointer to early marriage as a cultural practice. There was a lot of teenage pregnancy and child bearing age was a low as 15 years. Senior primary school was the highest and meant few would read and write properly. Many women engaged in business, piece work and other forms of livelihood activities. There were more Muslims than Christians and other religion precipitating Islamic practice and inclination to life in the two study sites. The study sites are highly ethicized by the Durumas a fact that explains the deep rooted cultural practices and Islamic subscription.

5.3 Recommendations of the Study

This study recommended 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. Also the study recommends that as poverty is an issue initiate Income generating activities both for men and women. Develop a work place program to net as many men as possible.

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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