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## RESEARCH ARTICLE

# MALE INVOLVEMENT AND WOMEN'S ACCESS TO ANTENATAL CARE (ANC) AT OMDURMAN MATERNITY HOSPITAL (OMH), SUDAN 2016

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**ABSTRACT**

**Background:** In developing countries men are the main decision makers affecting women access to maternity care.
**Objectives:** To investigate the effect of husbands' attendance on women access to antenatal care (ANC) at Omdurman maternity hospital (OMH) 2016
**Methodology:** A descriptive, cross sectional, hospital based study conducted at OMH. A ten percent of women attending ANC at OMH during the study period were included after an informed consent. Ethical clearance was obtained from ethical review committee (ERC) at OMH. Data was collected by trained data collectors using structured format, coded, edited, rechecked and analyzed by trained person using SPSS version 21.0.
**Results:** A total of 2822 women participated in the study. Male attendance in ANC was 1860 (66.0%), 989 (35.1%) of them always accompany their wives, 873 (30.9%) accompany their wives only in private clinics and 960 (34.0%) did not accompany their wives at all. Women accompanied by their husbands; 1430 (76.8%) were urban, while 432 (23.2%) were rural. Those not accompanied by their husbands; 206 (21.5%) of them were urban and 754 (78.5%) were rural (PV = 0.001). Both women and husbands were well educated, only 4.0%-4.2% were illiterate. Husbands' education has shown a significant difference in male attendance at ANC (PV = 0.0001). Women who were accompanied by their husbands; 1308 (70.2%) of them had regular ANC (four visits or more), while those not accompanied by husbands; only 145 (15.1%) had regular ANC, (PV = 0.001). Barriers affecting men from accompanying their wives for ANC were: work commitment 1259 (68.7%), presence of male affecting other women's privacy 346 (18.9%) or they consider it not important to accompany women for ANC 228 (12.4%). Most of women 2670 (94.6%) would like to be accompanied by their husbands. However, 1732 (61.4%) were satisfied with their husbands participation in ANC.
**Conclusion:** Women accompanied by their husbands had more regular ANC visits. Male participation in ANC was influenced by urbanization, husband education, and is affected by work commitment and other socio- cultural behaviors.



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## INTRODUCTION

Optimal utilization of ANC services could avert maternal and neonatal mortality and morbidity. WHO recommended a minimum of four visits across developed and developing countries. However, in developing countries women have the tendency of late ANC attendance, which affect the number of visits (Simkhada *et al*., 2008; Van Eijk *et al*., 2006). ANC can provide education, screening, detection and management of high risk pregnancies. Many socio-economic and cultural barriers affecting good utilization of ANC services, including; lack of trained health care providers, long travelling distance, lack of vehicles, poverty, illiteracy, family and husband, conflicts and wars, especially when women have little control over family finance (Caldwell, 1986). In developing countries; pregnancy, childbirth and birth spacing are considered; women's issues and males rarely accompany their wives for ANC (Kakaire *et al*., 2011). Male has to be involved in all

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forms of domestic activities including; sexuality, reproductive health and sharing decision making with their wives during pregnancy, delivery and birth spacing. Many studies have shown positive benefits of men involvement on maternal health, particularly increased access to ANC and post natal services (Redshaw and Henderson, 2013; Schaffer and Lia-Hoagberg, 1997). To our knowledge, there were no documented reports on male's involvement in reproductive health or ANC, which necessitates the need for this study to determine effects of husband's attendance on ANC, and utilization of ANC services as well as barriers against male participation in ANC with their wives at OMH.

## MATERIALS AND METHODS

This is a descriptive cross sectional, hospital based study conducted at OMH. A ten percent of women attending ANC at OMH during the study period were included. All women who attended on Mondays were included after an informed consent. Ethical clearance was obtained from ethical review committee (ERC) at OMH. Data was collected by trained data collectors, supervised by the authors, using a structured format. All women participated in the study were asked about the involement of their husbands in attending ANC with them. Data was coded, edited, rechecked and analyzed using SPSS version 21.0.

(30.9%) accompanied their wives only in private clinics. Women accompanied by their husbands; 1430 (76.8%) were urban, while 432 (23.2%) were rural. Those not accompanied by their husbands; 206 (21.5%) of them were urban and 754 (78.5%) were rural (PV = 0.001). Table 1 showed the distribution of women according to age, where there is no difference between age groups. Table 2, showed distribution of both husbands and women level of education, where only 4.0%-4.2% were illiterate. As seen in table 3; husbands' education has shown significant difference in male attendance in ANC (PV = 0.0001). Women accompanied by their husbands; 1308 (70.2%) have regular ANC, while 554 (29.8%) had irregular ANC, whereas those not accompanied by their husbands; only 145 (15.1%) have regular ANC compared to 815 (84.9%) had irregular ANC (PV = 0.001). Work commitment 1259 (68.7%) was the main barrier for men to attend ANC with their wives, followed by affecting other women's privacy, 346 (18.9%) and other 228 (12.4%) considered it not important to attend ANC with women, table 4. Almost all women 2670 (94.6%) would like to be accompanied by their husbands. However, 1732 (61.4%) were satisfied with their husbands participation in ANC.

## DISCUSSION

Male involvement in maternal health is considered as a social and behavioral change needed for men to play to ensure good

**Table 1. Age distribution of women attending ANC and role of husband at OMH**

| Age in years | Women accompanied by husband : N= 1862 | | Women not accompanied by husband: N= 960 | | Total N= 2822 | |
|---|---|---|---|---|---|---|
| < 20 | 043 | 02.3% | 110 | 11.5% | 0153 | 05.4% |
| 20- 30 | 858 | 46.1% | 856 | 47.5% | 1314 | 46.6% |
| 31-40 | 851 | 45.7% | 345 | 36.0% | 1196 | 42.4% |
| >40 | 110 | 05.9% | 049 | 05.0% | 0159 | 05.6% |
| Total | 1862 | 100.0% | 960 | 100,0% | 2822 | 100.0% |

**Table 2. Distribution of level of education of both husbands and wives affecting role of male in ANC at OMH**

| Level of education | Husbands: | N= 2822 | Women: | N= 2822 |
|---|---|---|---|---|
| Illiterate | 0113 | 04.0% | 0119 | 04.2% |
| Primary school | 0446 | 15.8% | 0514 | 18.2% |
| Secondary school | 1340 | 47.5% | 1232 | 43.7% |
| University or above | 0923 | 32.7% | 0957 | 33.9% |
| Total | 2822 | 100.0% | 2822 | 100.0% |

**Table 3. Effect of male education on participation in ANC at OMH 2016**

| Education | Males accompanying women for ANC; N= 1862 | | Males not accompanying women for ANC ' N =960 | | PV |
|---|---|---|---|---|---|
| Illiterate | 028 | 01.5% | 085 | 08.9% | |
| Primary school | 295 | 15.9% | 151 | 15.7% | |
| Secondary school | 850 | 45.6% | 490 | 51.0% | |
| University or above | 689 | 37.0% | 234 | 24.4% | |
| Total | 1862 | 100.0% | 960 | 100.0% | 0.0001 |

**Table 4. Barriers affecting men not to attend ANC with their wives (at all or in public health care facilities)**

| Barriers | No = 1833 | % |
|---|---|---|
| Work commitment | 1259 | 68.7% |
| Affecting other women's privacy | 0346 | 18.9% |
| Not important to attend | 0228 | 13.4% |
| Total | 1833 | 100.0% |

## RESULTS

A total of 2822 women were included in the study. Out of them, 960 (34.0%) were not accompanied by their husbands at all, while 1862 (66.0%) were sometimes or always accompanied by their husbands. Husbands who always accompanying their wives were 989 (35.1%), while 873

women and children health (Kaldar and Rjasingham, 1995). This study identified a high level of husband attendance at ANC (66.0%), 35.1% in public health clinics and 30.9% in private clinics only. This level is consistent with that found in South Western Nigeria 53.2%, Northern Uganda 65.4% and Kashmir 68.0% (Tweheyo *et al*., 2010; Kakaire *et al*., 2011). It is higher than that found in Maharashtra in India 35.5%,

Northern Nigeria 32.1%, Salvador and Greece 34% (Barua, 1998; Iliyasu *et al*., 2010). It is even more higher than that found in Eastern Ethiopia 19.7%, Cameron 18% and Benin in South Nigeria 13.9% (Fekede Asefa *et al*., 2014; Obi *et al*., 2013). This is high level may be explained by high level of urbanization or due to higher level of male education in the study group. Low levels of male participation were documented in many studies, particularly during childbirth. As seen in this study it is affected mainly by work commitment, especially in public clinics, as visits in public clinics are always during working hours which affects male participation in attending ANC. Usually private clinics has many time options away from working hours, which improves male participation. This is similar to that found in South Nigeria (Obi *et al*., 2013). Many studies on husbands' attendance on ANC, showed a more impact on women utilization of maternal health facilities (Barua, 1998; Iliyasu *et al*., 2010; Nwokocha, 2007). It is possible that male participation in ANC could be increased by increasing his knowledge on male role on ANC, where this can encourage women utilization of available facilities and more attendance of males at ANC (Olayemi *et al*., 2009). Also, male participation is affected by many social and cultural behaviors, where it is influenced by education and lack of knowledge. As seen in this study and many other studies it is more at level of higher education compared to low levels of education. Although husbands participation is optimal, many of their wives (61.4%), were satisfied, which may be influenced by socio-cultural reasons as well.

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**Conflict of Interest**

Authors declare that they have no financial or non-financial competing interest.

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