PARTICIPATION OF MALE SPOUSES IN MOTHERS' UTILISATION OF ANTENATAL CARE IN NJORO TOWN, NAKURU COUNTY, KENYA

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DECLARATION AND RECOMMENDATIONS

Declaration

This thesis is my original work and has not been published or presented for the award of a degree in any other university.

Signature..... Date.....

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Recommendations

This thesis has been submitted for examination with our approval as university supervisors.

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DEDICATION

This thesis is dedicated to my wife, Mary Rotich, my children, Hilda, Enock and Neema, my grandchild Favour, my late uncle Joseph Rotich, my father Paul Kipsat, and my mother Catherine Tamurey, for the different ways in which each encouraged me to strive for academic excellence.

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ABSTRACT

This study investigated the low participation of male spouses in mothers' utilisation of antenatal care, as a gender role, which is rare in many African communities. The study was guided by the following specific objectives: to determine the level of male spouse participation in mothers' utilisation of antenatal care; to assess the influence of male spouse participation in mothers' utilisation of antenatal care, Kenya; to identify the challenges associated with male spouse participation in mothers' utilisation of antenatal care. The study was carried out in the two health centres in Njoro town, Kenya. A total of 279 respondents participated in the study. Convenience sampling was used in carrying out the study. Structured interviews, focus group discussions and key informant interviews were used in data collection. Descriptive and inferential statistics were used to analyse quantitative data with the aid of Statistical Package for the Social Sciences (SPSS) software, at a significant level of $p< 0.05$. The findings of the study indicated that in overall seventy nine percent of the male spouses gave financial support and twenty eight percent making decision on the health facility to visit for delivery. Male spouse support in maternal nutrition during pre and post-partum was forty three percent, in breastfeeding twenty eight percent among other maternal support. The study findings show the age bracket of the male spouse affected their participation differently, for instance males spouse in the age bracket of 25-34 years were mostly affected by lack of finance and time at while those of ages, 35-54 and 55-60 years were least affected. The findings of this study would be useful in addressing some of the financial challenges, time from work and socio-cultural support, which were among the factors affecting male spouse participation in the mothers' utilization of antenatal care. The findings can also be useful in encouraging more male spouse participation on the mothers' utilization of antenatal care. Moreover, GoK, policy makers, NGOs and other stakeholders can use the information to increase the number of health care workers, and the expansion of existing health facilities. Health workers need to put more effort to encourage the willingness of male spouse participation in utilisation of antenatal care; and encourage spouse participation at their health facility especially at the County level. At the family level this would call for all the family members to participate in supporting the mother to utilise the antenatal care services.

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LIST OF ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
FGD	Focus Group Discussion
GOK	Government of Kenya
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
IYCF	Infant and Young Child Feeding
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KMA	Kenya Medical Association
KNBS	Kenya National Bureau of Statistics
MCH	Maternal and Child Health
MCHIP	Maternal Child Health International Programme
MDG	Millennium Development Goal(s)
MOH	Ministry of Health
MTPII	Medium Term Plan 2
NHSSP II	Second National Health Sector Strategic Plan
PMTCT	Prevention from Mother to Child Treatment
ROK	Republic of Kenya
SDGs	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
TBAs	Traditional Birth Attendants
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Fund for Population
UNGA	United Nations General Assembly
WHO	World Health Organisation

CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

The International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women, Beijing 1995 pointed towards the need for involving and encouraging men to take responsibility for their sexual and reproductive behaviour. They postulate that men are in a position to change attitudes and practices through their positions as community, religious and political leaders. It is further affirmed that individual responsibility as husbands and fathers to become involved in changing social attitudes includes taking responsibility for reproductive health issues. Male involvement has been slow, and the lack of progress is a likely contributor to the sub-optimal advancement towards the achievement of the United Nations SDGs 3 and 5 which seeks to ensure health and promote well-being for all at all ages and to achieve gender equality and empower all women and girls (UN, 2015)

Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1995), recognises that the unequal status of women in society hampers their equal access to adequate health care. Accordingly, the article obligates state parties to ensure that women have access to health care on equal basis with men. State parties are required to remove all legal and social barriers that obstruct access to health care for women. According to the African Charter on Human and Peoples Rights (ACHPR, 2014), particularly Article 14, the state parties are obligated to provide adequate, affordable and accessible health care services. Male spouse participation and support will facilitate the protection of female spouses as per the article in utilising antenatal care after delivery (Odimegwu, et al., 2005). The decision making power of women to utilise health services during pregnancy, childbirth, post-partum, newborn care and family planning is limited with decisions being taken by relatives and husbands, which may lead to delays in seeking professional care. Social responsibilities, such as the need for women to provide for the families and care for the young children, sometimes stand in the way of using or utilising the antenatal care services by limiting the time the mothers have for attending antenatal care and other health care services (Mbizvo & Bassetti, 1996). To increase male spouse participation in mothers' utilisation of antenatal care services and maternal health care services requires that the

providers gain in-depth knowledge and understanding of the men's health perspectives, behaviour and practices.

Pregnancy is not an illness; though it creates a great deal of physical and emotional demands on the mother. The husbands, as well as other family members need to understand and appreciate the discomfort and tiredness that pregnancy may cause in the woman. The awareness about the demands of pregnancy on the part of the husband and other family members could result in the necessary support the pregnant woman needs from the family members including the husband (Onyango, Owok and Ogutu, 2010). In the contemporary society, male spouses tend to overcome the patriarchal culture that frowns upon their participation in the maternal utilisation of antenatal care. Factors which discourage male spouses from being in the labour ward affect gender mainstreaming in the achievement of Sustainable Development Goals (SDG) on ensuring healthy lives and promoting the wellbeing for all at all ages (UNGA Report, 2015).

Male spouse participation in the mothers' utilisation of antenatal care is in line with the Kenya Government policies which seek to improve overall livelihoods by providing an efficient and high quality health care system. Infant and maternal mortality rates can be lowered by reducing inequalities in the health sector key areas (GOK, 2013).

1.2 Statement of the Problem

The presence of a male companion in antenatal care is a rare occurrence in many African communities. This trend is prescribed by tradition and it is, therefore, deeply entrenched. As an aspect of male spouse behaviour the trend has important implications for the use of antenatal care by women and it has negative consequences for the health of mothers and children. In Njoro town, Nakuru County, antenatal care is not fully utilised by the mothers. One reason for this undesirable state of affairs may be sought in the inadequacy of male spouse participation in the said utilisation. The government, through the Ministry of Health, has made efforts to intervene in this deficient situation so as to stimulate male spouse participation in the antenatal care. However, the level of such participation and the results of the interventions made towards improving it have so far been outlined only in general terms. There was thus need to carry out a study to find out the level of male spouse participation

understood as a gender role, and on this basis to chart ways of improving the mothers' utilisation of antenatal care, in the Kenyan counties.

1.3 Objectives of the Study

1.3.1 General Objective

The general objective of the study was to examine the factors associated with male spouse participation in mothers' utilisation of antenatal care in Njoro town, Nakuru County, Kenya.

1.3.2 Specific Objectives

a) To determine the level of male spouse participation in mothers' utilisation of antenatal care in Njoro town, Nakuru County, Kenya
b) To assess the influence of male spouse participation in mothers' utilisation of antenatal care in Njoro town, Nakuru County, Kenya
c) To identify the challenges associated with male spouse participation in mothers' utilisation of antenatal care in Njoro town, Nakuru County, Kenya

1.4 Research Questions

a) What is the level of male spouse participation in mothers' utilisation of antenatal care in Njoro town, Nakuru County, Kenya?

b) How does male spouse participation influence maternal utilisation of antenatal care in Njoro town, Nakuru County, Kenya?

c) What challenges are associated with male spouse participation in mothers' utilisation of antenatal care in Njoro town, Nakuru County, Kenya?

1.5 Justification

The Kenya Government in its 2013/2014 budget provided for free maternal delivery services in a bid to improve utilisation of antenatal care and thus reduce complications during pregnancy. The efforts by the government will consequently reduce maternal mortality rate, which at present is among the highest in the world (KDHS, 2010). Since women generally face life threatening complications during pregnancy, delivery and in postnatal condition, it is crucial that pregnant mothers be empowered to seek and utilise antenatal care. One way to do this is to involve their male spouses in this process. This involvement can be understood as a way of gender mainstreaming in the area of reproductive health care interventions. The

ultimate goal is to reduce the high rates of maternal and child deaths which may partly be due to poor utilisation of antenatal care services.

1.6 Significance of the Study

Understanding the level of male spouse participation in maternal utilisation of antenatal care may help in encouraging fathers to become more supportive in their antenatal care and breastfeeding gender roles (Mullick, Kumar and Wanjiru, 2008). Male spouse participation in the mothers' utilisation of antenatal care will increase the number of mothers utilising the antenatal care and delivery services thus reducing the maternal and child mortality rates through the elimination of the three types of delay, i.e. delay in seeking care, in reaching out to emergency obstetric care, and in starting treatment for any complication observed (Kululanga, 2011).

This study is part of creating the knowledge necessary for the achievement of the SDGs on maternal and child health care. It also contributes in achieving gender equality and equity at the local and county level. The knowledge generated will help in the realisation of the social demands of Vision 2030 and MTPII, which seek to improve the livelihood of Kenyans by providing an efficient and high quality health care system (ROK, 2007). The recommendations from the study will help to encourage male spouses as care givers to participate in the activities before, during and after delivery by their wives.

1.7 Scope of the Study

Participants in the study comprised the mothers who had used the maternal health care services in the past (retrospectively-MCH) and currently (prospectively-ANC) at 70 percent and 30 percent, respectively, in the Njoro Health Centre and Presbyterian Church Health Centre, in Njoro town.

1.8 Limitation to the Study

There were two limitations to the study. One was the policy and long protocol governing faith based health centres, which limits the collection of data for research from their institutions. The other limitation was the time for church programmes, which sometimes limited the time for focus group discussion or distracted some participants' attention, even though prior permission had been sought for the research activity.

1.9 Assumptions of the Study

The assumptions of the study were that there would be no medical staff strikes or other interruptions at the time of conducting the research, and that there will be willing participants in the research.

1.10 Definition of Terms

Antenatal Care: Refers to the medical care extended to a pregnant woman when she is expecting her baby and to her unborn baby throughout the pregnancy. Such care requires regular visits to a doctor/health facility or midwife.

Empowerment: The ability of women to exercise full control over their own action as far as utilisation of antenatal care is concerned. Empowering women enables them to become stronger, confident especially in controlling their lives and claiming their rights. For mothers to utilise antenatal care the male spouses should fulfil and make it possible for them to utilise maternal health care services.

Exclusive breastfeeding: The receipt of only breast milk (either directly from the breast or expressed). Only orals rehydration solution, drops and syrups (Vitamins, minerals, medicine) are permitted during exclusive breastfeeding, which normally takes place during the first six months after birth.

Gender mainstreaming: The process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all the areas and at all levels so as to achieve gender equity. Gender mainstreaming of the health care services would ensure that both genders participate in the utilisation of antenatal care services.

Gender: Refers to socially and culturally constructed differences between men and women, boys and girls. It also refers to typically masculine and feminine characteristics, abilities and expectations about how men and women should behave in society.

Infant: The child between birth and one year (twelve months) as the very young offspring of a human. Infants breastfeed exclusively for the first six months and continue with complementary feeding thereafter.

Influence: What male spouses do to make the mothers utilise antenatal care more fully and make their decisions regarding infant and young child feeding patterns.

Knowledge: Is that which is possessed by an individual and refers to their understanding of the topic or issue presented to them, for example the importance of antenatal care and infant and young child breastfeeding patterns.

Level of Male participation: Refers to the extent to which the male spouses participate in mothers' utilisation of antenatal care, their moral and financial support, discusses and takes part in the mother's antenatal care issues and makes a joint decision with the mother, as a couple and as when to seek and utilise antenatal care services.

Masculinity: The qualities and attributes regarded as characteristics of men. It is a set of attributes, behaviour and roles associated with boys and men. Hegemonic masculinity as encouraged in men is a configuration of gender practices which embodies the currently accepted answer to the legitimacy of patriarchy which guarantees the dominant position of men and the subordination of women. It is what causes male spouses not to participate in the mothers' utilisation of antenatal care.

Paternity leave: A period of time that a father is legally allowed to be away from his job so that he can spend time with his new baby and also to give moral and physical support to the wife.

Patriarchy: This is a social system in which the male is the primary authority figure; where husbands hold authority over wives, children and property. It implies the institution of male rule and privilege and entails female sub-ordination. It is used in reference to a society or institution regarded as being under repressive domination of men making decision on behalf of women without seeking their opinion or view.

Postnatal care: Attention and care given to the mother and baby after birth, for example special medical care and nutrition education or support.

Practical gender needs: These are the needs formulated from the concrete conditions of women experience. They are the needs women identify in their socially accepted roles in society and also as a response to immediate perceived necessity, for example water provision, healthcare and employment. These are the needs the mothers require from the male spouses as their support in utilisation of antenatal care.

Prenatal care: A type of preventive care with the goal of providing regular checks that allows the doctor or midwife to treat and prevent potential health problems throughout the course of the pregnancy, while promoting healthy lifestyles that benefit both the mother and the child.

Reproductive health: This is a complete physical, mental and social wellbeing in all matters relating to the reproductive system. It implies that mothers are able to have satisfying and safe sex life, the capability to reproduce and freedom to decide if, when and how often to do so. It is what enables antenatal care to be a subject.

Stereotype: It is a thought that may be adopted about specific types of individuals or certain ways of doing things but that belief may or may not reflect reality. It is a generalisation about

a group of people whereby a defined set of characteristics is attributed to this group. This will refer to the mind set of male spouses concerning the participation in antenatal care as a women affair and thus justifying non participation.

Strategic gender needs: These are the needs women identify with because of their sub-ordinate position to men in their society and they vary according to context, for example the abolition of sexual division of labour.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviews the literature as an account of knowledge that has been undertaken by established scholars and experts in the field of study and making a discourse on the male spouse participation in mothers' utilisation of antenatal care and their influence on maternal utilization of antenatal care.

2.2 Level of Male Spouse Participation in Mothers' Utilisation of Antenatal Care

A study on Nepal reports that 40 percent of male spouses accompanied their spouses in attending antenatal care for the first time. Greater decision-making power for mothers was associated with lower male spouse participation in mothers' utilisation of antenatal care (Britta, Mullany, Becker and Hindu, 2007). One of the reasons reported in that study for low male involvement in maternal health care was that many men felt marginalised and left out of the mother and child care services. The International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women, Beijing 1995 pointed towards the need for involving and encouraging men to take responsibility for their sexual and reproductive behaviour. They postulate that men are in a position to change attitudes and practices through their positions as community, religious and political leaders. It is further affirmed that individual responsibility as husbands and fathers to become involved in changing social attitudes includes taking responsibility for reproductive health issues.

Male involvement has been slow, and the lack of progress is a likely contributor to the sub-optimal advancement towards the achievement of the United Nations SDGs 3 and 5 which seek to ensure health and promote well-being for all at all ages and to achieve gender equality and empower all women and girls (UN, 2015).

For male spouses to enjoy the information and benefits from the mothers' utilisation of antenatal care, their participation should not end at the door to the delivery room but should continue up to delivery process (Cohen and Burger, 2000).

Although men play a key role in the family as the main decision-makers, many studies on determinants of utilisation of Skilled Birth Attendants (SBAs) have focused largely on socio-demographic and maternal characteristics. Additionally, most of the efforts to address these

determinants, and thus to increase male spouse participation in the utilisation of antenatal care and uptake of maternal health services have mainly addressed the mothers. Little has been done to involve the male partner in maternal health. Studies on male involvement in family planning have shown that men play a key role in family planning decisions, either through their direct participation or by enabling their partners to use contraception (Mulick, Kunene and Wanjiru, 2008). Apart from this, no other study has been done to establish the level of male spouse participation in the utilisation of antenatal care. Male spouse participation in the mothers' utilisation of antenatal care remains as a big challenge given the negative socio-cultural beliefs associated with their participation.

A study in Kano, Nigeria, showed that 17.2 percent of women did not attend regular antenatal care because of husbands' denial based on masculinity influence, lack of facilities and knowledge (Adamu and Salihu, 2002). In Uganda, despite the health facilities being in close proximity to the mothers seeking antenatal care, mothers continue to report late for antenatal care and deliver outside the health facilities due to the fear of sexual harassment by health care workers (Kululanga, 2011). Previous studies in Uganda and Malawi have shown that most mothers attend antenatal care only once instead of the recommended four times and never return for delivery at the health centres. Societal allocation of roles to men and women, especially as far as decision making is concerned, had a bearing on mothers' utilisation of antenatal care. It was therefore important for men to understand and appreciate the importance of attendance of antenatal care, There is an inclination to suspect that pregnant women have sexual intercourse with men who are not their husbands, and that men have sex with pregnant women who are not their wives (Nyane, 2007). This would discourage and serve as a pretext for those reluctant to accompany their spouses to attend antenatal and postnatal care and delivery to stick to their practice of non-involvement.

Most cultures, especially in Africa, regard pregnancy and delivery as a female domain. Therefore, men are often not expected to accompany their wives to the antenatal care clinic or be present during delivery (Mulick, Kunene and Wanjiru, 2008). As decision maker for the family, decisions around when, where and even if, a woman should have access to healthcare often fall on men. Particularly in patriarchal societies, the health status of women and children suffer especially where women have little control over family finances, little say in

decision making and restricted freedom of movement. A study in Tanzania found that households headed by men were associated with more home based deliveries, while in Pakistan high decision making power by men was linked to low utilisation of antenatal care and delivery care services (Hou and Ma, 2011).

In this study, factors attributed to Kenyan male spouse participation in the mothers' utilisation of antenatal care were used in encouraging more male spouses to participate in the mothers' utilisation of antenatal care. Attempts to encourage men to attend for antenatal care and childbirth have been promoted by individual health facilities in Kenya, with mixed successes and failures from other parts of poor resource settings (Kululanga, 2011).

According to the KDHS, 2010 and 2014 report, both the county and national government target to improve reproductive health by raising the number of visits by women to antenatal care centres to four and increasing antenatal care coverage to 90 percent of mothers by 2015. The current antenatal attendance level stands at around 61 percent as per the KDHS, 2014. Traditional beliefs have also contributed to low utilisation of antenatal care in Kenya and in some communities in Uganda (Nyane, 2007).

A study carried out in Asembo, a rural district in Nyanza Province, western Kenya where fishing and subsistence farming are the main economic activities in the area showed a culturally homogeneous population with the majority of the residents belonging to the Luo ethnic group. Polygamy is practiced by many communities in Kenya. Polygamy is highest in Nyanza Province, and about 21 percent of women are in a polygamous relationship. Health indicators and utilisation of health facilities are poor in the study area compared to the rest of Nyanza Province and Kenya.

2.3 Influence of Male Spouse Participation in Mothers Utilisation of Antenatal Care.

A study conducted by the United Nations Population Fund (UNFPA, 2013) in Kenya found that husbands greatly influence women's decisions to use reproductive health services such as family planning (UNFPA 2014). With regard to maternity care, various studies emphasise how men's role can contribute to better outcomes for their pregnant wives (UNFPA, 2015). In most families, the men are empowered financially and are the main decision-makers in all

issues including reproductive health. They may use this opportunity to ensure that their pregnant wives seek maternity services or arrange for skilled care during delivery, if delivery takes place at home. For men to make the right decision for their wives regarding place of delivery and professional attention, they need to understand the importance of maternal health care (Mullany, 2004).

There is a general agreement that men who know the danger signs of pregnancy are more likely to act fast to save the lives of their wives (Cohen and Burger, 2000). In Kenya, most of this education is given to the mother when attending antenatal care. Factors associated with male spouse participation on the mothers' utilisation of antenatal care will be key in finding out the ways of improving the utilisation of antenatal care by encouraging male spouse participation either directly or indirectly. To date, few studies have tried to assess specifically whether male spouse who participate influences other men to ensure that their wives utilises antenatal care and get professional attention during the antenatal care visits.

User fees for maternity health care have been removed as per the Health Care Policy (2012-2030), which seeks to ensure all expectant mothers access quality health care and deliver in the nearest maternity health facility under the supervision of a skilled health worker. In Kenya, there are substantial discrepancies between the levels of utilisation of prenatal care services, delivery services and consequent postnatal services (UNFPA, 2013) across counties, with counties like Kirinyaga, Nyeri, Nairobi, Meru and Mombasa. Reporting at least 70 percent level of utilisation while at the lower end are counties like West Pokot, Kilifi, Mandera, Turkana and Wajir at 5 percent to 17 percent (UNFPA, 2014). This study therefore, sought to find out the gaps that still exist in spite of efforts being made to encourage male spouse participation in utilisation of antenatal care so as to increase the number of antenatal and postnatal care visits which would subsequently reduce maternal infant mortality rate in the various counties as well as nationally.

2.4 Challenges Associated with Male Spouse Participation

Understanding the factors influencing the utilisation of appropriate antenatal care content is a matter of great policy concern to the government and other stakeholders, especially donors. Hitherto, there has been no study in Kenya attempting to understand the factors influencing the utilisation of antenatal care content. In other parts of the world, several studies have been

done showing factors that affect the male spouse participation in the utilisation of antenatal care and its content (Osungbade, Oginni and Olumide, 2008). The studies done in Uganda were undertaken to understand the factors influencing the utilisation of antenatal care in general with no particular attention to the content of care (Kyomuhendo, 2007).

In the same vein, the factors influencing the utilisation of antenatal care in a general picture have been widely studied. Maternal education, maternal employment, age, poverty, and access to the media are some of the factors influencing the utilisation of antenatal care services (Saxena, Chadwick, Dhillon and Kambo, 2006). The differences in economic status amongst prospective mothers explain the differences in accessibility and utilisation of antenatal care services. The distance to the health facility or travel time to the health facility are important factors explaining consistent utilisation of antenatal care services. Other significant factors found are polygamous union, husband's education, parity, and female empowerment. Surprisingly, previous birth complications such as stillbirth or Caesarean section were insignificant in influencing early prenatal booking (Adenkale and Isawumi, 2008). Other studies (Saxena et al., 2006) highlight the importance of awareness of care during pregnancy and knowledge of pregnancy-related complications in influencing utilisation of antenatal care services in India.

Male partners play an important role in women's reproductive health hence more attention should be paid to how to incorporate men in various relevant interventions, as part of gender mainstreaming in the area of reproductive health (ADB/ADF, 2007). Men also have a personal and social responsibility for their own sexual behaviour and the effects of that behaviour on the health and wellbeing of their partners and children (Kululanga, 2011). Observational studies have shown that educating men about the importance of health care for the family increases the promotion of some health seeking behaviours such as utilisation of antenatal care services (Britta, 2004). Educational interventions in pregnancy health have traditionally been inadequate in addressing a woman's degree of influences within the household on health related decisions (UNICEF, 2011). Although men's participation in maternal and child health (MCH) care is crucial, there is not much evidence of the participation of male spouses in mothers' utilisation of antenatal care and of their influence in infant and young child feeding. The exclusion of men from MCH services, reinforced by the

erroneous notion that pregnancy and child birth are uniquely feminine (Ilyazu, Abubakr, Galadana, and Aliyu, 2010) and maternity units exclusively meant for women, might be deterring male spouses from participating in the mothers' utilisation antenatal care. Women's reproductive health is considered a "woman's" affair among the Samburu community and so it is dishonourable for men to concern themselves with such issues (UNFPA, 2015).

When men participate in antenatal care, their knowledge of women's experiences before and after birth increases, their behaviour becomes supportive, and their receptive attitude to postnatal care in medical centres may also increase. In recent times, multiple efforts have been implemented by government and non-governmental organisations (UNFPA, 2013) to encourage men to participate in taking their wives to obstetricians and gynaecologists. However, only a few men have responded in most of the developing countries as per the scanty studies done so far (Kwambai, 2013). Women's ability to seek health care or implement lessons learned from health education interventions are often determined by the receptiveness and the support of the household head who is usually the husband.

It was apparent from the literature survey that most of the interventions and programs dealt with the general determinants of access to antenatal care services. The socio-economic differences amongst mothers in relation to the content of antenatal care are scarcely captured in current literature. This study extends the existing literature by analysing the factors influencing the utilisation of antenatal care content. This should provide more informative insights to policy makers about potential public health strategies that can increase the uptake of appropriate antenatal care content in Kenya but much more effort is required in order to arrive at the desired level of male spouse participation (UNFPA, 2013).

According to the letter of intent by the Private Sector Advisory Panel for advancing maternal and new born health in Kenya (GOK, 2013), the panel committed itself to supporting, advancing, mobilising and harnessing the necessary resources to fight maternal and newborn death and morbidity and promote a culture in which every pregnancy is wanted, every child birth is safe and every young person can make use of their full potential. This will be achieved by among others calling upon corporate executives and other development stakeholders to join efforts to prioritise and mainstream maternal and newborn health through

their companies' welfare policies, common business practices and corporate social responsibility initiative (GOK, 2013).

2.5 Theoretical Framework

This study was guided by Functionalist and Liberal Feminism theories. The functionalist perspective sees society as a complex system and suggests that gender inequalities exist to maximise social efficiency. This approach looks at society at the macro-level and broadly focuses on the structures that shape society as a whole. The functionalist perspective of gender inequality was largely developed by Talcott Parsons' model of the nuclear family (Uja, Aisen, Mutihi, Vanderagt, Glew and Uguru, 2005). As per this perspective, gender role inequality manifests itself in the utilisation of antenatal care and maternal nutrition. The division of labour and household chores works to maximise resources and efficiency. A structural functionalist view predefined gender role as complementary for women to take care of the home while men seek for jobs so as to provide for the family. Thus gender, like other social institutions contributes to the stability of society as a whole. Functionalism focuses on the structures of society and their functional significance (positive or negative consequences) for other structures. The functionalist theory accounts for changes in the lifestyles which results in shared responsibilities within the increasing family size. This theory was used to get a deeper understanding on how the traditional gender roles and societal perceptions thereof has contributed to inequalities so as to be able to come with practical solutions to reduce or alleviate the problem. It also helped to understand why males are less involved in mothers' utilization of antenatal care and areas where they provided support as linked to their traditional role as providers.

The Liberal Feminism theory, which is based or anchored on the ideals of equality and liberty, has a bearing on gender relations (Uja et al., 2005). The liberal conception of equality was based on the understanding that all humans have the potential to be rational and that any inequality has to be justified in rational terms. The theory argues that the reason women appear to be intellectually inferior is due to their inferior education and this apparent inferiority was, therefore, a result of inequality rather than a justification for it Liberal feminists believe that culture and ideology are responsible for women's oppression. The oppression is located in the exclusion of women in all spheres of life resulting in the inequalities between men and women. Inequalities are manifested by the way the society

allocate gender roles .The empowering roles were allocated to men while women were allocated roles which are domesticated such as child care, reproductive and antenatal care among others, (Parpart et al, 2000) posits in contemporary society there are strong expectations, even by women themselves, that women should take primary responsibility for work involved in nursing children and making a home, (Parpart et al, 2000)

These roles are shunned traditionally by men and are perceived to be exclusively a woman's domain. This is why feminists believe that dealing with this exclusion of either gender and elimination of discrimination by providing opportunity to all could be a panacea for women's liberation, (Parpart et al, 2000).They advocate for equality of spouses in all spheres as well as shared responsibilities. Liberal feminist theory is used to justify the need to involve men too in the antenatal care to ease the burden women face in the private while undertaking work in the public. Male spouse participation in the mothers' utilisation of antenatal care will change the perception that antenatal care utilisation is a women's issue and encourage child care as a shared responsibility of both spouses. Liberal feminists focus on equal opportunity for men and women in all spheres of endeavour (Dyson and Moore, 1993).

This theory was useful in shedding light and a deeper understanding accounting for the low male spouse's participation in the mothers' utilisation of antenatal care by attributing it to the inequality between gender roles which liberal feminist were fighting against. The Functionalist and Liberal Feminist theories complement each other by looking into the inequalities between male and female spouses that would affect the utilisation of antenatal care. The liberalist believes that the society is not static and, therefore, changes that affect the family should be embraced by both spouses to promote gender equality. Thus, the male spouse other than providing finances and moral support to the mother in utilisation of antenatal care must be ready to share responsibility at the home front such as child care, domestic chores and other incidentals to ease the burden women face. The male spouse should utilise the paternity leave to support the female spouse during antenatal care.

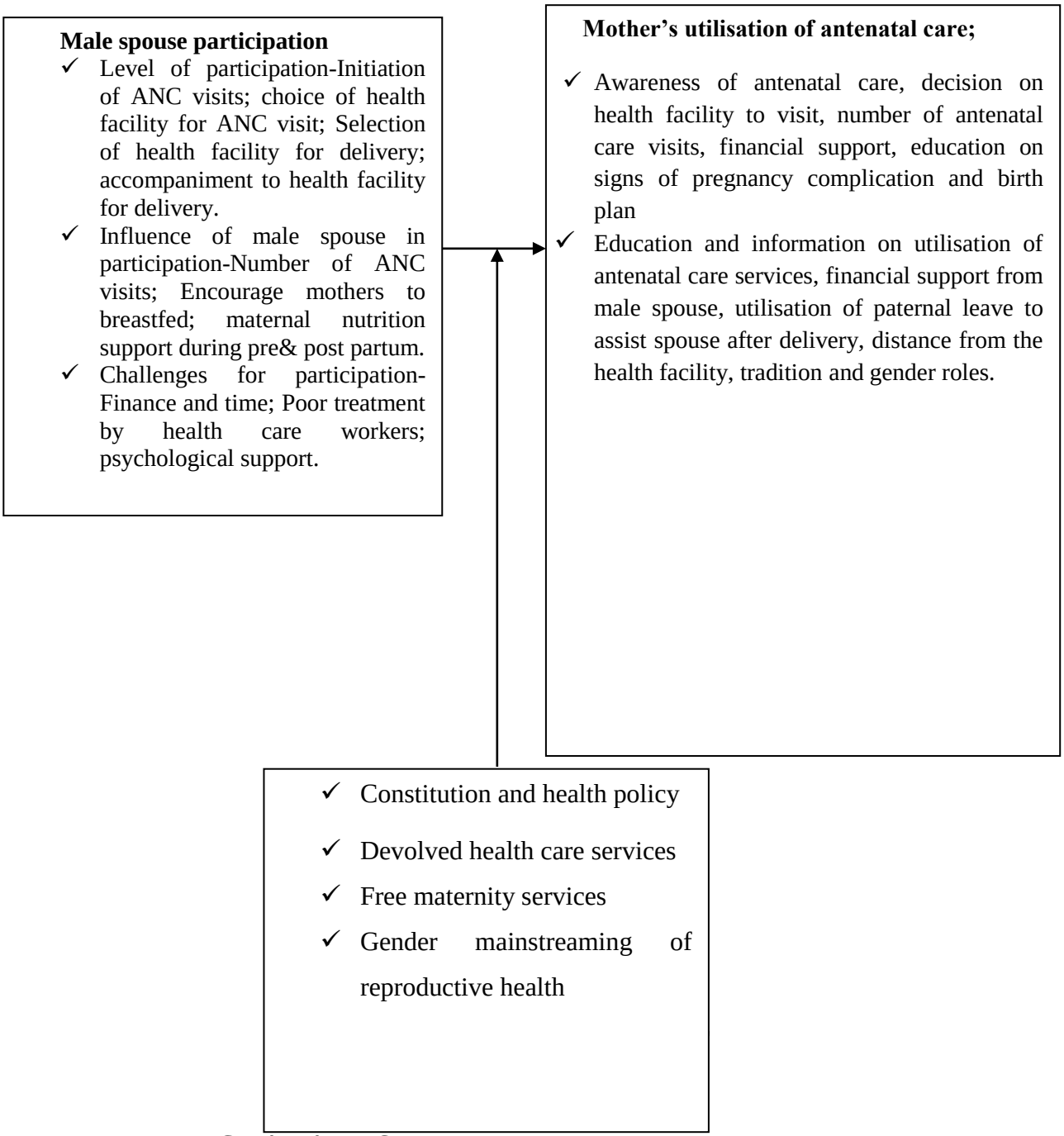
2.6 Conceptual Framework

This study postulated that male spouses who participate in the mothers' utilisation of antenatal care were more likely to make decisions which would favourably influence the utilisation of antenatal care. This was manifested by encouraging mothers to attend antenatal care through financial, moral and emotional support. The conceptual framework shows the relationship between independent and dependent variables in the study. Mothers' utilisation of antenatal care services is categorised as a dependent variable. Male spouse participation stands as an independent variable.

Male spouse level of participation in antenatal care services is measured against their participation in the initiation of antenatal care visits by the mothers, the support they give to the mothers and the choice of health care facility to visit for antenatal care and delivery. Low male spouse participation in mothers' utilisation of antenatal care services would lead to low utilisation of these services by the pregnant women, mothers and their children, which in turn would lead to high maternal and infant morbidity/mortality. Intervening variables like background information (socio-economic background) and cultural factors were taken into consideration as they were captured in the questionnaire.

Variables Interaction: The participation of male spouses in the mothers' utilisation of antenatal care, independent, dependent and intervening variables interacted as shown in Figure 1. The independent variables were measured by the level of male spouse participation, their influence on infant and young child feeding patterns and the factors associated with their participation in the utilisation of antenatal care by mothers. The frequency and percentage of maternal utilisation of antenatal care was measured in terms of the mothers' timing of antenatal care, decision on the choice of health facility, financial support, antenatal care services utilised and the type of support they received from the male spouse. Intervening variables were the health care policy and the Constitution of Kenya (2010) which interacted with both variables (independent and dependent).

INDEPENEDENT VARIABLE **DEPENDENT VARIABLE**



INTERVENING VARIABLES

Figure 1: Relationship between the independent and dependent variables

CHAPTER THREE
METHODOLOGY

3.1 Introduction

This chapter explains the research design used, the location of the study, the population of study, sampling procedures, sample size, instruments, data collection procedure and data processing.

3.2 Research Design

A descriptive survey design was employed in the study using mothers attending antenatal care. The survey provided the information on the mothers utilising antenatal care service at the time of the study at Njoro health care facilities thus generating information on the male spouse participation in the mothers' utilisation of antenatal care.

Each of the indicators was assigned a weight of one (1). To get the weighted score of each of the roles the male spouse participated in, the percentage scored as raw score was multiplied by the weight and divided by hundred percent and this could range from 0 percent for non-participation to 100 percent for participation in all the activities and a score of 0 to 3 were considered as low participation and a score of 4 to 6 as high participation.

3.3 Location of the Study

Njoro town is one of the fastest growing towns in Nakuru County with a population of twenty-nine thousand (Kenya population 2009 Census), with approximately 1000 women expected to become pregnant annually (KDHS, 2010). The town is 172 km North West of Nairobi, 18 km West of Nakuru town and 5 km North of Egerton University. The annual growth rate as per the Kenya Demographic and Health Survey 2014 is two point nine (2.9) percent, with a sex ratio of one male to three females, translating to 7300 males to 22000 females (1:3). Njoro town has two faith based health centres, namely Huruma and Tunza Jamii, run by the Catholic Church and the Presbyterian churches respectively. The Njoro Health Centre is a government facility. Njoro town was chosen because of its high annual birth rate of 3 percent per year and also due to its rural-urban status (KNBS, 2010).

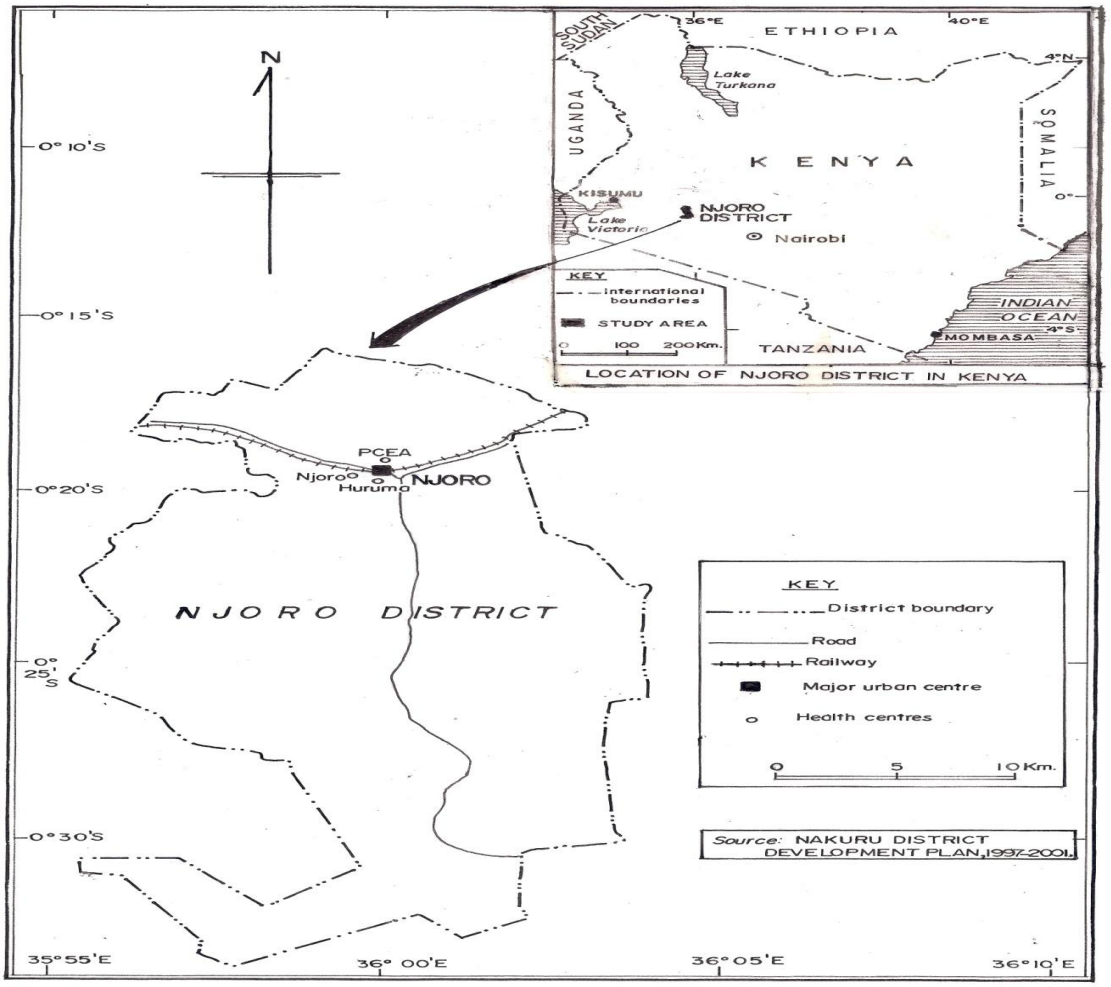


Figure 2: Map of Njoro town Nakuru Couny, Kenya

3.4 Population of the Study

The study population comprised of mothers utilising antenatal care services in Njoro, at the time of the study in the last two years preceding the study consented to participate in the study. To get more information on the study, mothers and male spouses were selected to participate in the Focused Group Discussion (FGD). The FGDs for mothers and male spouses were used to generate information about male spouse participation in the mothers' utilisation of care services.

Mother's spouses attending antenatal services in Njoro town

Table 1. Population of the study

HEALTH CENTRE	REGISTERED MOTHERS
Njoro Sub Councty	700
PCEA-Tunza Jamii	240
Total	940

Source: (Adopted from Njoro and PCEA Health Centres, 2016)

3.5 Sample Size Determination and Sampling Procedure

To obtain the sample size of the respondents, the percentage of mothers attending antenatal care was used as to calculate the sample size for the survey. The sample size (n) was calculated using Kish Leslie formula (1996).

$$n = \frac{z^2 * (p * q)}{d^2} = \frac{(1.96)^2 X (0.76)(0.24)}{0.05^2} = 279$$

Where: z =1.96.

p= 0.76

q=1-p =0.24

d=0.05

Proportion of mothers attending antenatal care involved in maternal health in Njoro town was sourced from the antenatal care clinic register.

Convenience sampling technique was used in the study to select the mothers attending antenatal and postnatal care because of the shared characteristic of being mothers and for utilising antenatal care services at the health care facility. Their homogeneity provided the required information with respect to the objective of the study (Mugenda and Mugenda, 2003). Njoro Sub county and PCEA health centres in Njoro were selected for the study because of the large number of mothers who visit the maternal child and antenatal care services as per the health centres' record registers.

The health facilities in Njoro were chosen based on the provision of antenatal care services and the number of women who visit them for antenatal care services. A total number of 279 were recruited randomly as respondents to participate in the questionnaire. As for the FGDs, 28 male spouses and 18 mothers of various age categories participated in each of the two FGDs. The study involved two key informants from the two health centres.

Table 2: Sampled population

HEALTH CENTRE	TARGET POPULATION	SAMPLE SIZE
Njoro	700	201
PCEA	240	78
Total	940	279

Source: (Modified from Njoro and PCEA Health Centres, 2016)

3.6. Instrumentation

The questionnaires was used in collecting information on socio-demographic data which included the age, education level of the female spouse, their occupation and their marital status among, marital status, prior knowledge on antenatal care services, distance to the health facility, and number of children born to the mother among others. The level of male spouse participation in maternal utilisation of antenatal care included consideration of their decision making, financial support, and their initiation of antenatal care visit, their choice of health facility for antenatal care antenatal care visit and for delivery.

A FGD guide was prepared by the researcher to steer the discussions in each of the four groups. The guide for the FGD covered the issues which had been raised in the questionnaire on the male spouse participation in mothers' utilisation of antenatal care, culture, religion and delivery services and postnatal care. A total of four FGDs were conducted with both male and female spouses, based on their perception and level of participation in the utilisation of antenatal care.

The FGDs were held two months after the administration of questionnaires. The participants were conveniently selected based on their willingness and interest to participate in the discussion. The participants were divided according to the age category and from each category and from each category three respondents were given the opportunity to participate in the discussion. The age categories with fewer respondents were all allowed to participate in the discussion. The researcher had a prior meeting with the team leaders who were briefed on the criteria for selecting the participants to the discussion.

The administrator and the chief nursing officer of the health centres were the two key informants in the study. The interview guide was designed so as to get more information on the accessibility and utilisation of antenatal care services in their facilities for delivery services and what could be done to improve male spouse participation.

Table 3.Four Focus group discussions by location.

FOCUS GROUP	**Gender**	**TOTAL**
1.Njoro P.C.E.A Industrial	Male	14
2.St.Lwanga Catholic Njoro	Male	14
		28
3.Huruma Estate	Mothers	9
4.St.Augustine Catholic church	Mothers	9
Total		**18**

3.6.1. Reliability

The reliability of the instruments refers to its stability over time or the level of its internal consistency to determine how scores in one item correlate with the scores of other items in the instruments as recommended by Fraenkel and Wallen (2000) and Mugenda and Mugenda (2003) to accept or reject the results. The instrument (questionnaire) was tested for consistency, reproducivity and precision by trying the instrument at Mother Kevin health centre in Nakuru. Results from the study in the Nakuru health centre, affirmed the reliability of the study at

α coefficient of 0.8

3.6.2 .Validity

The Validity of the instruments refers whether the instruments measured the required variables. Triangulation of data was used to validate the data obtained in the study. The instrument measured and answered the research questions by yielding accurate results which were also validated by FGDS and the key informants' interviews.

3.7. Data Collection Tools

The researcher sought the help of the administrators and the chief nursing officers for a meeting and a briefing with the mothers attending the antenatal clinic. The researcher briefed the respondents on the purpose of the study and respondents gave their consent before administering of the questionnaires. The questionnaire was administered to the mothers as they waited to be attended to and some after being attended to by the health care workers. The mothers who were not able to write were interviewed by the researcher and the questionnaires filled for them. The FGDS were carried out after the administration of the questionnaires. The researcher sought the help of the church pastors and administrators to mobilise the groups of men whose spouses had utilised antenatal care and mothers who had used antenatal care services for the discussions after church service or mass.

The key informant interviews were conducted last and it involved the administrators and the medical officers in charge of the PCEA-Tunza Jamii and Njoro-Sub County health centres .The Key informant was used as a tool to verify and validate key issues raised in both the questionnaires and FGDs as pertains to the male participation in spouse utilisation of antenatal care. The key informant interview was important and necessary because of their first-hand in depth knowledge about the utilisation of antenatal care services in their health

facilities and within the community. The key informants are usually experts at the ground and are the decision makers in their health facilities and at the community level.

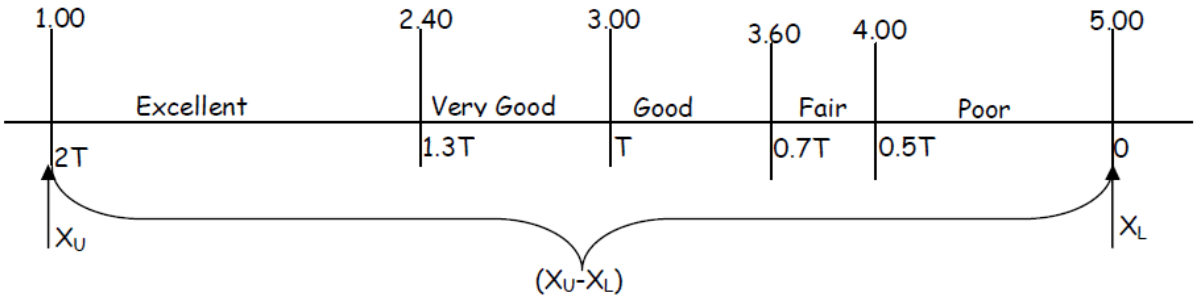
3.8 Ethical Consideration

The researcher obtained the research permit by seeking for approval from the Ethics and Research Committee of Egerton University. The approval from Ethics and Research Committee was then used to get research permit from the National Commission of Science, Innovation and Technology, the County Commissioner, the Executive County Officer of Health and the Njoro Sub-County Commissioner

. Information obtained was used for the purposes of the study. The researcher practiced veracity, non malfeasance and beneficence by being honest, straightforward, causing no harm or embarrassment and by doing good to the respondents.

3.9 Data Processing.

The data collected was entered and coded for analysis with the aid of Statistical Package for Social Sciences (SPSS) version 23.0. Descriptive statistic was used to analyse the data gathered. Inferential analysis was carried out to determine the influence of male spouse participation on maternal utilisation of antenatal care qualitative data from the level and influence of male spouse participation in mothers' utilisation of antenatal care at the confident level of P <0.05. The level of male spouse participation was determined by using evaluation weighed score formula.



Where, T = Target

Xa = Actual Achievement

Xu = 2T = Upper Criteria Value

XL = 0 = Lower Criteria Value

Span = 4, ie (5.00 -1.00)

2T Twice the target (200%) =excellent; 0.5 T is half the target (0%-50%)

Computation of the Raw Score entails determining the point at which the achievement falls within the range 1.00 to 5.00. The value of the raw score determines the level of male spouse participation.

Step 1: Determine the actual level of male spouse participation in ANC, Xa and calculate the % change (Δ) with respect to the target.

Determine the percent (%) of achievement as follows;

$$\% \text{ Change} = \frac{(\text{Actual} - \text{Target})}{\text{Target}} \times 100$$

Step 2: Apply the formula

$$\text{Raw Score} = \text{Upper Criteria Value Limit} + \text{Span} \left\{ \frac{X_U - Xa}{X_U - X_L} \right\}$$

$$\text{Raw Score} = 1.00 + 4.00 \left\{ \frac{X_U - Xa}{X_U - X_L} \right\}$$

Note: Xu =2T and X_L =0

Therefore,

$$\text{Raw Score} = 1.00 + 4.00 \left\{ \frac{2T - Xa}{2T - 0} \right\}$$

$$\textbf{Raw Score} = \mathbf{1.00 + 4.00} \left\{ \frac{\mathbf{2T - Xa}}{\mathbf{2T}} \right\}$$

Where,

Upper Criteria Value Limit = 1.00, Span = 4.00,

T = Target and Xa = Actual Achievement.

Step 3: Compute the Composite Score

The Composite Score of the indicators is computed by adding up the raw scores of all the indicators. The Composite Score ranges from 1.00 to 5.00.

Thus Composite Score = SUM (Weighted Score) = Σ (Weighted Score)

Table 4.Composite score table level of Male Spouse participation

		Range-%	Raw score	Remark
1.	100	200	1.00 to 2.40	Excellent
2.	76.9	99.9	2.40 to 3.00	Very good
3.	53.9	76.9	3.00 to 3.60	Good
4.	38.5	53.9	3.60 to 4.00	Fair
5.	0	≤ 38.50	4.00 to 5.00	Poor

CHAPTER FOUR
RESULTS AND DISCUSSIONS

4.1 Results

Introduction

This chapter presents analysis and findings of the study as set out in the research methodology. The study aimed at establishing the participation of male spouses in mothers' utilisation of antenatal care and their influence in the utilisation of antenatal care and the challenges associated with their participation. The researcher worked with a total sample of 279 mothers attending antenatal care clinic in Njoro town, government and faith based health facilities.

The results are presented in 5 sections. Section 4.1 focuses on socio-demographic characteristics for female spouses in the study; Section 4.2 shows the level of male spouse participation in mothers' utilisation of antenatal care. Section 4.3 assesses the influence of male spouses in mothers' utilisation of antenatal care. Section 4.4 identifies the challenges associated with male spouse participation in mothers' utilisation of antenatal care. Lastly section 4.5 discusses the results generated by the study.

4.2 Socio-Demographic Characteristics of the Respondents

The study sought to assess the socio-demographic characteristics of the respondents in terms of age, education, occupation, marital status, religion, number of pregnancy and number of children born to the mother.

Table 5.Demographic Characteristics of the female respondents (n = 279)

Indicator	Frequency(n)	Percentage
Age		
17-24years	164	58.8
25 years and above	115	41.2
Education level		
Primary	70	25.1

Indicator	Frequency(n)	Percentage
Secondary	128	45.9
Tertiary	47	16.8
University	33	11.8
No formal education	9	3.2
Occupation		
House wife	130	46.6
Employed	103	36.9
Business	46	16.5
Religion		
Christian	273	97.8
Muslim	6	2.2
Marital status		
Married	253	90.7
Single	14	5.0
Widowed	4	1.4
Separated	6	2.2
Divorced	2	0.7
Prior knowledge of ANC service		
Yes	225	80.6
No	54	19.4
Distance to health facility		
Less than 5km	176	63.1
5km and more	103	36.9
Source of information on ANC		
Health care workers	136	48.7
Books and media	64	22.9

Indicator	Frequency(n)	Percentage
Relatives, friends & church	79	28.4
Mean number of children born to the mother	3	SD=(1.769)
Mean umber of pregnancy to the mother	2	SD=(1.171)
Mean number of living children	3	SD=(1.803)

The results in table 3 show the background information of the mothers utilising antenatal care which indicated that 58.8 percent aged between 17-25 years and 41.2 percent aged 25 years and above. The study showed that 45.9 percent and 25.1 percent of the female spouses had secondary and primary education levels respectively. The results indicate that 46.6 percent of the females were housewives, 36.9 percent and 16.5 percent of the female spouses were employed and had businesses. The study showed that 90.7 percent of the female spouses were married, with 5.0 percent and 2.2 percent single and separated respectively.

On the knowledge of antenatal care services 80.6 percent mothers were aware and 19.4 percent were not aware of such services. On the aspect of distance to the health facility, 63.1 percent of the respondents lived within the radius of 5km while 36.9 percent lived more than 5km from the health facilities in Njoro town.

Health care workers were reported as the main source of information by 48.7 percent of the mothers, 22.9 percent indicated books and media as the source of antenatal care information while 28.4 percent mentioned relatives, friends and church as their source of antenatal care information. The mean number of children born to the mother and living was three with standard deviation of (1.769) and (1.803) respectively, while the mean number of the pregnancy to the mother was two (SD-1.171).

4.3 Level of Male Spouse Participation in Mothers' Utilisation of Antenatal Care Services

The level of male spouse participation depends on who initiates the first visit for the antenatal care visits among the male spouse, female spouse and the combined initiative of either partners or spouses. Figure 2 shows the proportion of both male and female spouse initiation of antenatal care visit in the study.

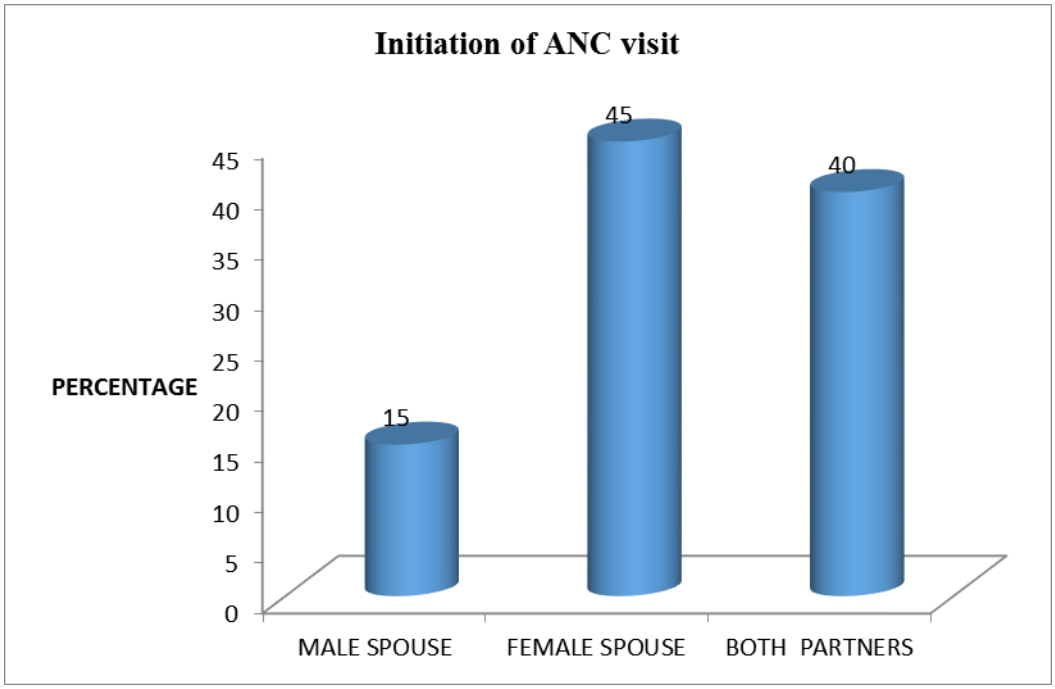


Figure 3 initiation of ANC visit among study population

From figure 3, Male spouses who initiated the antenatal care visit were 15 percent compared to 45 percent female spouses who initiated the same. Antenatal care initiated visits by both spouses stood at forty (40) percent.

4.3.1 Decision Making on Selection of Health Facility for Antenatal Care

Maternal utilisation of antenatal care was determined by the level of decision making in the choice of health facility to visit for antenatal care services by both the male respondents and their spouses. The results in figure 3 indicate the participation of male spouse in deciding on the health facility to visit for antenatal care in the study.

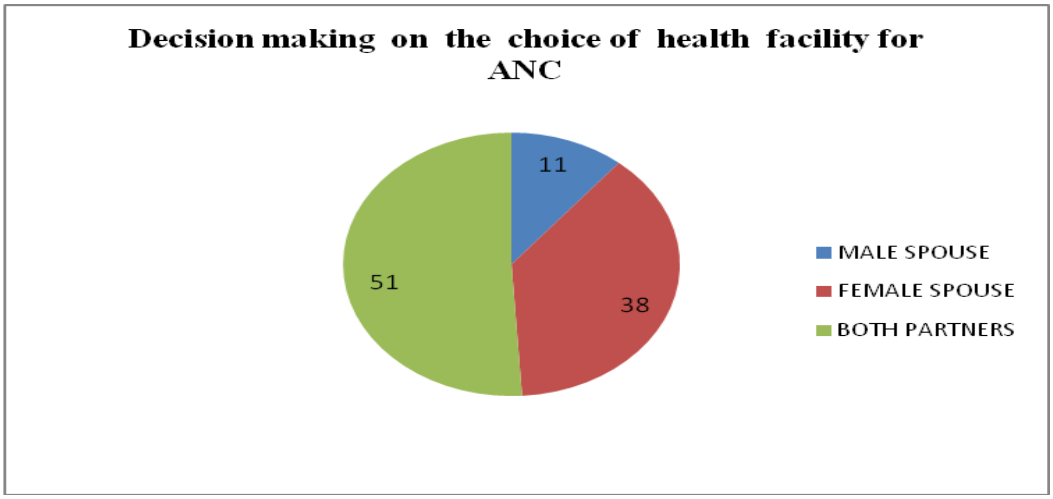


Figure 4.Decision making levels on the choice of health facility to visit for antenatal care

Figure 4 shows that 11 percent of male spouses made decision on the choice of the health facility to visit for antenatal care while joint decision making was 51 percent and 38 percent of the mothers made decision on the choice of health facility to visit for antenatal care.

4.3.2 Financial Support

The level of contribution of male spouse to the financial support to antenatal care services during the antenatal care visits is indicated in figure 3.

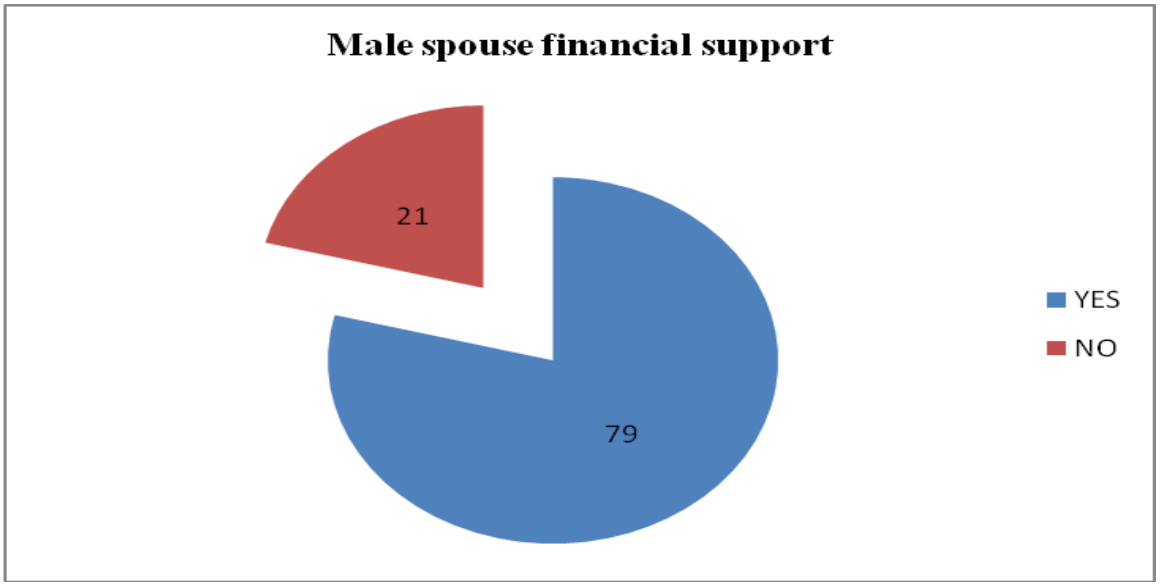


Figure 5 Male spouse financial support to their spouses attending ANC

The study indicates that 79 percent male spouses provided financial support in form of fare for their spouses to attend antenatal care. Twenty-one (21) percent of male spouses did not provide financial support. The financial support was mainly in the form of fare and where necessary money for lab test.

4.3.3 Selection of Health Facility for Delivery

Selection of the health facility for delivery by the male, female and both spouses/partners is shown in figure 3 Male spouse participation in the selection of the health facility for delivery was 28 percent while the selection by female spouse alone was 26 percent.

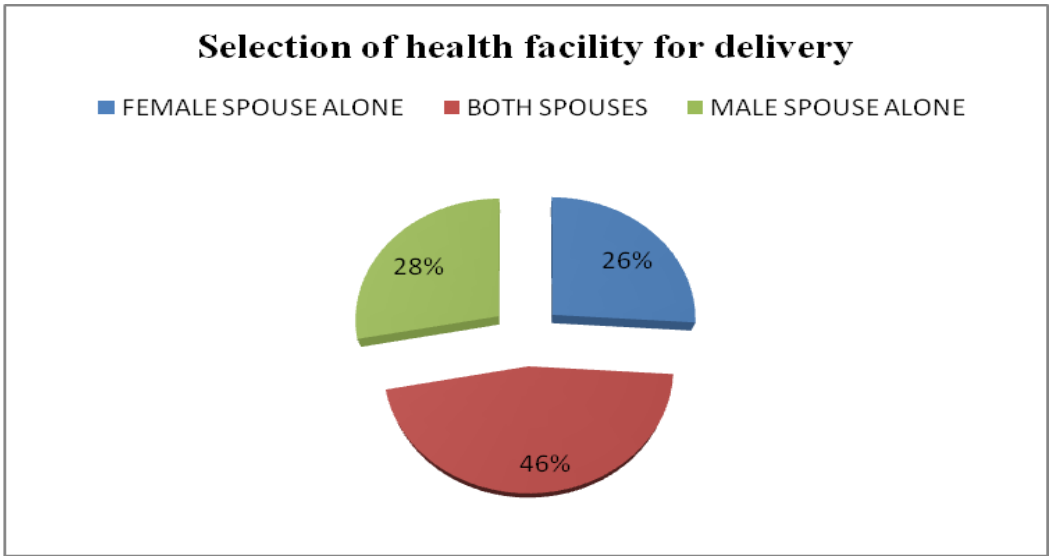


Figure 6 Decision making levels on the health facility to visit during delivery

4.3.4 Accompanying of Spouse to Health Facility during Delivery

The success or gains made in the mothers' utilisation of antenatal care was determined by the percentage of male spouses who accompanied their female spouses for antenatal care visits. Figure 7 shows the proportion of male spouses who accompanied their spouses to the health facility during delivery.

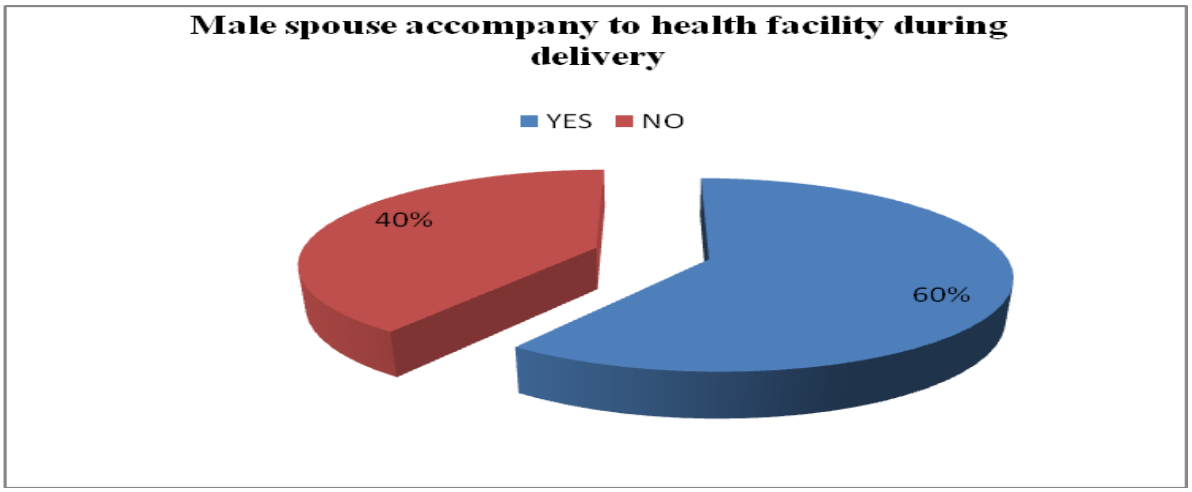


Figure 7 Male spouses who accompanied their female spouse to health

Figure 7 indicated that 60 percent male spouses accompanied their spouses to the health facility for delivery to ensure they reached hospital safely but could not enter into the delivery room compared to 40 percent who did not.

4.4 Male Spouse Influence on Mothers' Utilisation of Antenatal Care

Male spouses are expected to provide support to their spouses during pregnancy thus influencing their utilisation of antenatal care. Their influence was through provision of finances and socio support.

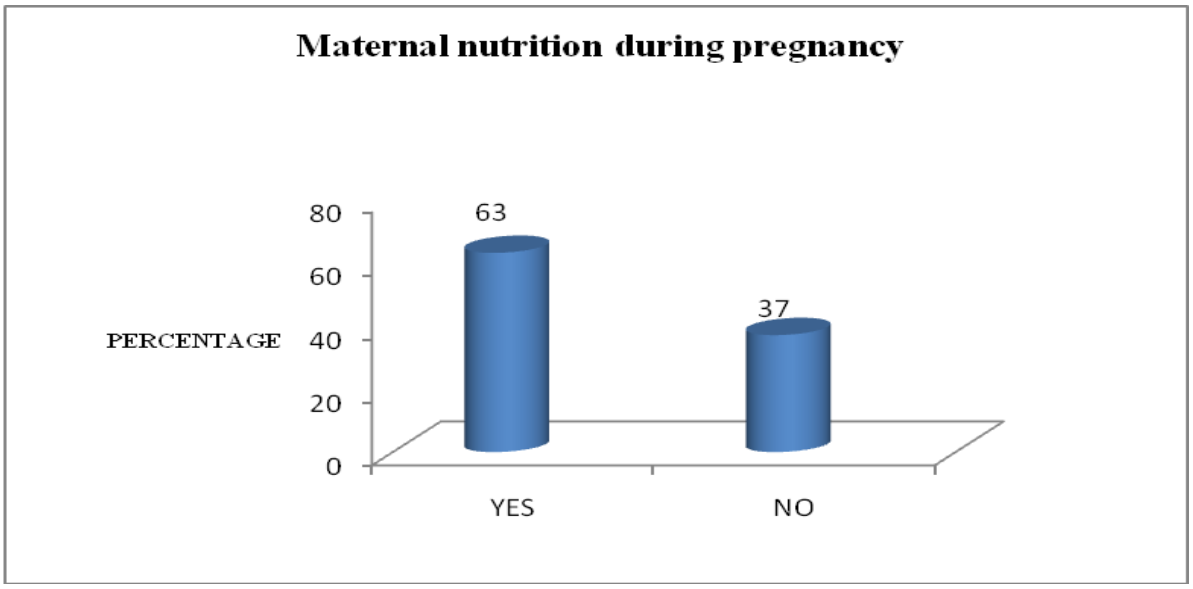


Figure 8 Male spouse contribution to maternal nutrition during pregnancy

From figure 8, Male spouses who were reported to support the mothers in terms of maternal nutrition during the pregnancy were 63 percent as compared to 37 percent of male spouses who did not give any support for maternal nutrition during prenatal and postpartum.

Table 6 Level of male spouse participation in utilisation of antenatal care

LEVEL OF MALE SPOUSE PARTICIPATION	**PERCENTAGE (%) Target**	**Recorded Achievement**	**Raw score**	**RANKING**
Initiation of ANC visit	100	15	4.7000	Poor
Choice of health facility for ANC	100	11	4.7800	Poor
Financial support	100	79	3.4200	Very good

Choice of health facility for delivery	100	28	4.4400	Poor
Accompaniment to health facility for delivery	100	60	3.8000	Good
Male spouse nutritional support during pre- and post-partum	100	63	3.7400	Good
Total	**600**	**256**	**24.8800**	**Fair/low**

Source-Kenya National Bureau of Statics (KNBS) 2010

The overall results indicates a total percentage of 256 percent (2.56~3) out of the possible 600 percent (6), indicates a low male spouse participation in the utilisation of antenatal care services.

4.4.1 Male Spouse Support for Mothers' Utilisation of Antenatal Care.

As the mothers returned home and embarked on child nursing, the male spouses encouraged the mothers to breastfeed and also provided the financial, moral and social support in household chores. This was to ensure that the mothers fed well, did not over-work and were able to concentrate on child care and feeding.

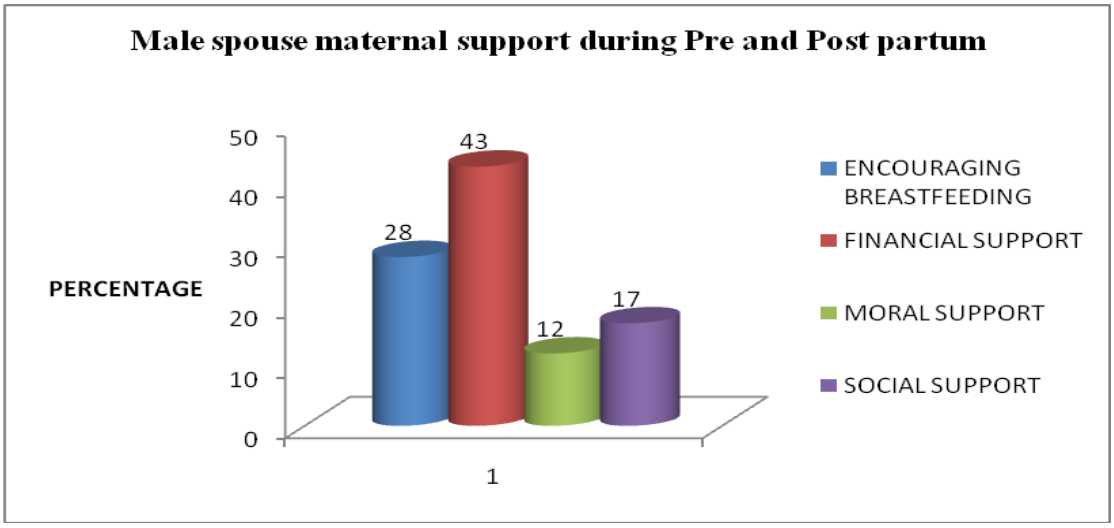


Figure 9 Male spouse nutritional support to the mothers during pre- and post-partum

Figure 9 shows male spouse participation in the mothers' utilisation of antenatal care by providing support as follows: 28% male spouse provided support by encouraging the mother to breastfed, 43% male spouse provided financial support ,12% provided moral support, and17% gave Social support,

4.5. Focus Group Discussions

Male spouse participation in the maternal utilisation of the antenatal care was affected by several issues ,the feeling by men was that accompanying female spouses to the health facility for antenatal care was not a serious issue that would require their attention unless the lives of the mother and or the baby was in danger (i.e. mothers at risk). Though male spouses were willing to participate in enhancing maternal utilisation of antenatal care, some mothers during the FGDs reported that they were hesitant in allowing the involvement of male spouses or bringing them on board because of the fear of being criticised by the society that they domineered over their husbands and felt that it negatively affected their ego. Discussion with the health care administrators and chief nursing officer corroborated the information gotten from the questionnaires and the FGDs.

According to the nursing officer at the Njoro Health Centre, the level of male spouse participation in the maternal utilisation of antenatal care was low. Long queues and few health care workers were confirmed by the informants as one of the deterring factor and hoped the county government would give it priority in order to improve the health care services.

Male spouses reported that they do not usually participate when their wives are attending antenatal care because some of their spouses do not discuss anything with them. When asked about their roles in ensuring utilisation of antenatal care, the male spouses responded that they have a role in seeing that their female spouses attend antenatal care as instructed by the doctor. The male spouses have the responsibility of ensuring that the welfare of the mother and the child are catered for, their spouses do not over-work during pregnancy and after birth, get nutritious food and are comfortable and happy. Male spouses aged 34-54years also reported that their spouses usually experienced mood swings during pregnancy. Most of the men did not understand how to overcome the emotions and challenges of taking care of their pregnant spouses and therefore they would require psychological support as shown in figure 4.6. Male spouses reported that they have roles of providing financial support, doing

household chores like cooking, washing utensils, fetching water and providing moral and emotional support to their female spouses when pregnant. The male spouses played the roles as follows:

(i) Overall 36 percent provided financial support however when distributed by age, it varied as follows: men aged 25-34years, 30% provided financial support through purchase of food and all the necessities required by the mother; for those aged 35-54years and 55-60 years, 20 percent and 50 percent did so respectively.

(ii) To enable their female spouse to attend antenatal care, the male spouses in the FGDs indicated that they do household chores depending on their ages as follows: 25-34years, 4 percent; 35-54years, 38 percent; and 55-60years, 38 percent. The younger ones played less roles compared to the middle aged because of being out looking for finance from business and employment. The mothers-in-law, grandmothers and sisters helped to some extent on the social support and in household chores during the pregnancy and after delivery thus also easing the burden on the younger men. The elder ones played bigger roles both financial support and in household chores as most of them had stabilised in terms of business and employment. This group gave financial support due to their experience on the maternal care during pregnancy.

4.5.1 Male Spouse Influence on Mothers' Utilisation of Antenatal Care

Male spouses reported that they influenced mothers utilisation of antenatal care by providing the money required for buying the food required by the mother like bone soup and uji to enhance breast milk production. They also hired or paid for house help to assist their spouses in taking care of the infant and house work chores. Where they do not hire, they sought the services of the mothers-in-law, sisters-in-law and other close relatives. During the male FGD, 60 percent of the reported to have only provided moral support for immediate breastfeeding, and none reported to have directly requested the mother to immediately breastfeed, help hold the newborn during the first breastfeeding.

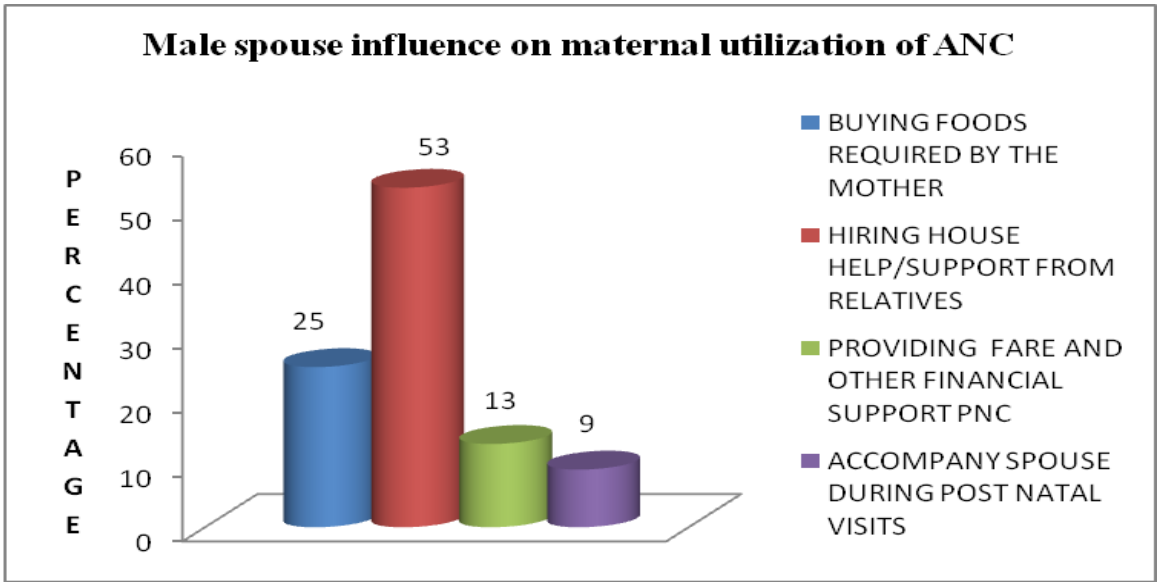


Figure 10 Type of support provided by the male spouses to enable infant breastfeeding.

Figure 10 demonstrates male spouses support during maternal utilisation of antenatal care. Through buying nourishing foods for the mother (25 percent); hiring of house help to assist the female spouse after delivery with household chores and the baby care or seeking support from relatives like grandmother, mother-in-law and other relatives (53 percent); through accompanying spouse when attending postnatal clinic (13 percent) and providing fare and other financial support (9 percent).

4.5.2 Factors Affecting Male Spouse Participation in the Utilisation of ANC

The Catholic and PCEA churches in Njoro, being the mainstream churches with large congregations, have managed to reduce the patriarchal disposition among its followers though a few still hold on to traditional cultural views that antenatal care visits and or antenatal care utilisation is a woman's domain**.**

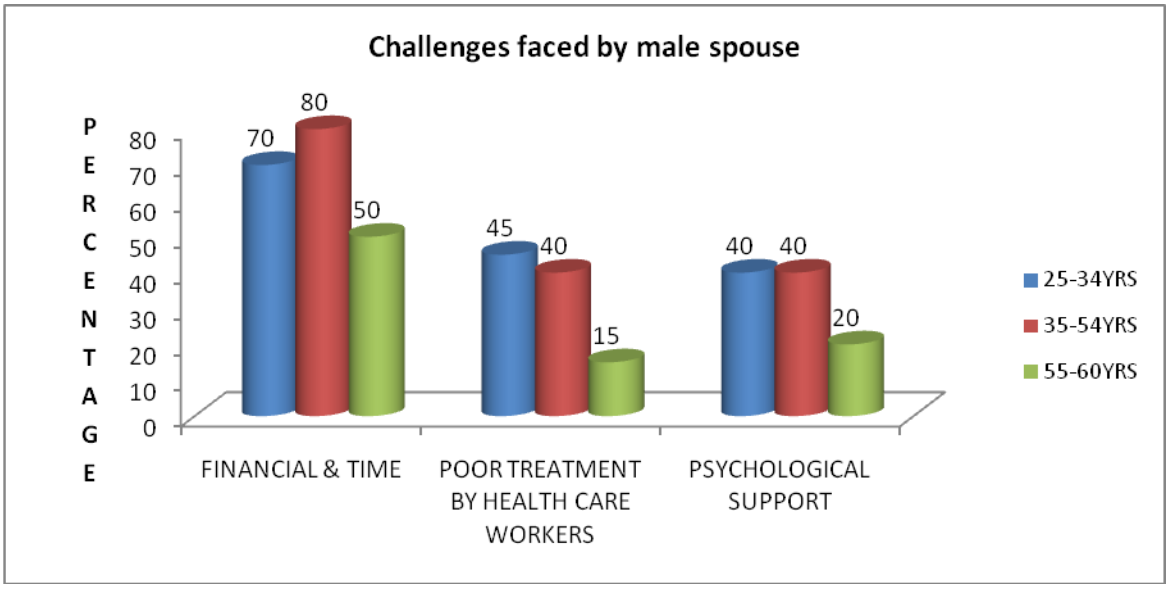


Figure 11 Challenges Faced by Male Spouses

FGD also dealt with the challenges experienced by male spouses during their participation in the maternal utilisation of antenatal care. The challenges were varied with respect to age of male spouse. Fifty (50) percent of male aged 55-60 years faced more challenges with respect to finance and time as compared to 70 percent of male spouse aged 25-34yeras and 80 percent of those aged 35-54years as indicated in figure 8.

Poor treatment by health care workers affected 45 percent of male spouse aged 25-34years, compared to 40 percent of male spouse aged 35-54 years. Male spouse aged 55-60 years were least affected due to the respect and attention they were accorded. Results also shows that 40 percent of both Males spouse aged 25-34years and 35-54years reported to require psychological support to overcome spouse emotional mood swings as compared to 20 percent of those aged 55-60 years.

4.6 Discussion

The discussion is based on the data collected and analysed as per the set objective of the study. The discussion gives discourse of other related results from previous related studies.

4.6.1 Level of Male Spouse Participation in Maternal Utilisation of Antenatal Care

The level of male spouse participation was determined by their frequency of participation in influencing decision on the timing of antenatal care visits, financial support for antenatal care visits, and decision on the health care facility for delivery. The implication is that the latter group (ages 55-60) were stable financially and attached great importance to the antenatal care while the mid age group had other financial obligations like school fees, medical bills rents and other expenses thus giving little for maternal support. The fact that antenatal and maternity were free contributed also to reduced support from the male spouse.

The male spouse participation in the mother's utilisation of antenatal care was low and this finding is consistent with the FGDs whereby the male spouses alluded to the fact that they were willing to accompany their female spouses during antenatal care visit and during delivery if they had a complicated pregnancy or what is referred to as a "high risk mother". They also ensured that the mother attended all the required antenatal care clinics and reached hospital timely for her delivery. Male spouses' selection of the health facility for delivery was slightly high in the study. Male spouse contribution was high in study due to the campaign and awareness created by the health care provider on the dangers or risks encountered by the mother when there is a delay in seeking for maternal health care. These findings corroborate the findings from recent studies in Malawi (Kululanga, 2011) that reported low male spouse participation in the mother's utilisation of antenatal care.

The level of male spouse participation in decision-making on initiation of antenatal care services in Njoro sub-county was low for both male and female spouses when compared to other studies in Uganda, Nepal and India (Bua, 2008). According to these studies, joint decision-making by the couples on the initiation of antenatal visits and choice of health facility to visit for delivery were high in Nepal and India at over 70 percent (Britta, 2007).

There was a difference between male spouse participation through accompanying female spouse for antenatal visits and during the accompanying to the health care facility for delivery. The difference could be attributed to the risks between the accompanying during antenatal care visits and the actual day of delivery.

4.5.2 Male Spouse Influence on Mothers' Utilisation of Antenatal Care

The study revealed several factors associated with male spouse participation in the mothers' utilisation of antenatal care services. Socio-cultural perspective that antenatal care issues were "women issues" was one of the factors that affected the level of male spouse participation. Male spouses informed that whenever they participate in the antenatal care issues other men take them to be under the control of their wives and are also deemed to be "sat on" by the latter affecting their ego. However, the elderly men in the FGDs felt that there was need to encourage the women to use the services in order to identify complications early and save the mother and infant life. The same was expressed by some of the mothers that pregnancy is a female dominated area and men were involved when the mother experienced complications.

Although men's participation in the mothers' utilisation of antenatal care is low, they play a vital role in the safety of their female partners' pregnancy and childbirth and should therefore not be construed as negligence or "don't care attitude". Both male and female spouses felt that attending antenatal care was a woman's issue, as this was stipulated by culture and tradition; therefore, men could not go out of their way in ensuring the utilisation of the same.

According to a study carried in Asembo, western Kenya (Kwambai, 2013), men were positive in their views about antenatal and delivery care; as decision makers they often encouraged, some even "forced" their wives to attend antenatal or delivery care at the nearest facility. Many reasons as to why it was beneficial to accompany their wives were provided, yet few did this in practice unless there was a clinical complication or risk to the life of the mother and the child. In terms of cultural perspective there is a change in terms of male spouse participation as antenatal care is no longer considered women pre-dominant affair. With changing lifestyles and gender roles, both gender roles are currently acknowledged as key in the success of the antenatal care utilisation.

4.5.3 Challenges associated with Male Spouse Participation in Mothers' Utilisation of ANC

The finding of this study is consistent with findings of another study carried out in South Africa in 2005. In this study, service providers noted with concern that men held onto negative traditional beliefs, for example that a man would lose strength or standing in the society if he saw a naked woman or walked and sat with women (Mullick et al., 2005). This then implied that some men would not escort their female spouses to the health centres for maternal health services. It is assumed that when the female spouses do not have complicated pregnancies, they do not utilise antenatal care services as recommended by WHO and, therefore, the health care service providers need to sensitise the community and encourage more of male participation in maternal utilisation of antenatal care and health care services.

The FGDs also identified issues of finances as a challenge in enhancing participation of male spouse in the utilisation of antenatal care. Men acknowledged it was their responsibility to provide financially. When finances are scarce or low, this then influenced the choice of health facility to attend for antenatal care. Lack of finances for fare, lunch, laboratory tests and other necessities required during the antenatal care period posed as challenges that hindered male spouse participation. Tight time schedules and difficulties in getting permission to be away from work limited male spouse participation in antenatal care visits. Some men felt they would rather spend time looking for money to take care of the entire family.

According to this study, poor attitude of health workers and fear of being harassed by health workers were some of the reasons contributing to both low male and female spouse participation in the utilisation of antenatal care. Other studies in Kenya have shown that poor behaviour of service providers adversely affect male and female spouse participation and capacity to use reproductive health services (Fapohunda & Rutenberg, 1999). The nursing officer at the Njoro Health Centre confirmed that the level of male spouse participation in the utilisation of antenatal care was low. Long queues and few health care workers were confirmed by the informants as one of the discouraging factors and hoped the county government would prioritise the improvement of the health care services.

Health care policy does not allow men and un- authorized persons entry into the delivery room in Kenyan public hospitals and health centres and this may be part of the reason why some men are not showing keenness in accompanying their partners for maternal health care. Men in the FGD expressed little willingness to participate in the whole process of delivery and at best ensured that their spouses reached hospital in good time and were in the care of the health care workers. In private health centres like PCEA Njoro, there is practically no restriction for male spouses who are willing to accompany their spouses to the delivery room. Similar findings were reported in the study carried out in Natal, South Africa, where few men indicated that even when they accompanied their partners to the clinic, they generally waited outside for the outcome (Mullick et al., 2005). Since most public hospitals are heavily occupied they may not be able to accommodate male spouses into labour wards. Staff shortage in health facilities may also not be conducive to allowing male spouse in case of need. These findings imply that much as there is advocacy for increased shared gender roles and male spouse participation in maternal health, a great deal needs to be done in terms of infrastructure and logistics to enable male spouse participation in the utilisation of antenatal care.

The challenges faced by male spouse in their participation in the utilisation of antenatal care varied in terms of age, with 50% of the men aged 55-60 years facing more challenges and men aged 25-34 years having 30% and men aged 35-54 years being less challenged financially. Time to look for money and provide food was also a challenge as reported by male spouses during the FGD. Poor attitude by the health care workers discouraged male spouse participation and accompanying spouse to the health care facility for antenatal care. Age of the health care workers attending to the antenatal care going mothers deterred both the male and female spouse as they did not like being attended to by young staff who they consider as their children and are, therefore, not comfortable with them.

In the male FGD younger and older men highlighted reluctance on the part of their spouses to share healthcare and antenatal care visit reports, which contributed to low male spouse participation in the mothers' utilisation of antenatal care. Some men reported that their spouses did not brief them on any antenatal care visit while some men got reports on the progress on the growth of the foetus, the weight of the mother and other physical or blood

tests carried out. The mothers report from the antenatal care visits enhanced the knowledge of their male spouses thus making them part of the process with the mothers affirming the cultural practices and belief that the man's role is to provide transport and check on the child health card .These findings are consistent with several other studies that have reported that even when men encourage their partners to seek care and get involved there is still lack of information on postnatal care (Kululanga, 2011). In Nepal, women who shared information with their husbands were more likely to experience heightened male spouse participation (Arora et al, 2000). Similar findings reported in a study carried out in Nepal in 2003 suggest that the level of male awareness of the services offered during antenatal and postnatal care in Njoro town is still low. Lack of discussion between the spouses after the antenatal care visit contributed to the low level of awareness by the male spouse.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the study findings, conclusion of the study and recommendations drawn from the findings of the study. The purpose of the study was to find out the level of male spouse participation in the mothers' utilisation of antenatal care, male spouse support for mothers' utilisation of antenatal care and the factors affecting male spouse participation in the utilisation care in Njoro town, Nakuru County. This was to help define the importance of the male participation in the maternal health care and identify any existing gaps.

5.2 Summary of the Findings

The study in summary was guided by the following specific objectives: to determine the level of male spouse participation in mothers' utilisation of antenatal care; to assess the influence of male spouse participation in mothers' utilisation of antenatal care; and to identify the challenges associated with male spouse participation in mothers' utilisation of antenatal care in Njoro town, Nakuru County, Kenya. Structured interviews, FGDs, and key informant interviews were used in data collection. Information obtained from the FGDs corroborated the information received from the questionnaires. The findings of the study indicated that the level of male spouse participation in mothers' utilisation of antenatal care in the form of initiation of antenatal care visit was 15 percent, the male spouse decision making on health facility for antenatal care was 11 percent, male spouse financial support was 79 percent, while decision on health facility to use for delivery was 28 percent. Male spouse support in maternal nutrition during pre and post partum in terms of financial support was 42.5 percent, breastfeeding was 28 percent, social support was 17.5 percent, while moral support was 12 percent. The study findings show that male spouse participation was affected depending on their age, for instance those in age bracket 25-34 were affected by lack of finance and time at 70 percent; those aged 35-54 at 80 percent, while the ones in the age bracket 55-60 at 50 percent.

5.3. Conclusion

Although a high proportion of males' spouses in Njoro town were aware of the antenatal care, most of them did not accompany their spouses during the antenatal care visits despite being instrumental in making decision on selecting antenatal care facilities. With respect to the health facility choice for delivery, a good number of male spouses discussed with their spouses. Financial support, though a challenge, was one of the supports that steadily came from the male spouses with the provision of fare being the outstanding one. Level of male spouse participation in utilisation of antenatal care and their influence in maternal young child nutrition in Njoro town was low in both the retrospective and prospective surveys and therefore more effort is required to encourage male spouse participation in the utilisation of antenatal care and maternal health care services.

Factors that were found to affect the level of male spouse participation in the mothers' utilisation of antenatal care and their influence on the utilisation of antenatal care were lack of finances, free time from work, socio-cultural issues as well as masculinity, patriarchy, and poor attitude of health care worker to client. Male spouse participated keenly in the utilisation of antenatal care when there was a complication or high risk on the pregnancy.

5.4 Recommendations

The implications of the finding at individual level are that; i) Health workers need to put more effort to encourage the willingness of male spouse participation in utilisation of antenatal care; ii) Health workers and community health workers should encourage spouse participation at their health facility especially at the County level. At the family level this would call for all the family members to participate in supporting the mother to utilise the antenatal care services; iii) Health workers need to develop messages that stimulate male spouse participation in maternal utilisation of antenatal care and their influence on infant young child nutrition. This is likely to achieve increased utilisation of maternal health care services and to balance gender roles in reproductive health if done effectively.

This study recommends the following in order to improve utilization of antenatal care:-

5.4.1 Need to enhance awareness of male spouse participation on utilization of antenatal care by mothers.

In order to raise the level of awareness and the importance of male spouse participation in the mothers' utilisation of antenatal care, the County government of Nakuru should revive and enhance the extension and community outreach services through visits to the community, churches, chiefs barazas and other forums where the importance and benefits of using antenatal care and infant and young child feeding is expounded. From the outreach and extension, the level of male spouse participation in the mothers' utilisation of antenatal care is expected to improve. There is need, therefore, to involve male partners so that the goals for Maternal Child Health Care and Women's Reproductive Health can be achieved by reducing morbidity and mortality (Anangwe, 2008). Urban, rural and slum settings present unique challenges with regard to maternal and young child nutrition due to their physical and socio-economic characteristics. Njoro town has rural, urban and slum dwellings which make basic government services including health care services limited and this, coupled with financial constraints, leads to a substantial proportion of women delivering at home or using the services of the midwives or traditional birth attendants (TBAs) who may not be able to handle complicated cases**.** Sensitisation plays a pivotal role in creating awareness on various issues as well as their importance. Concerted efforts should be undertaken by the community leaders, healthcare workers, churches and political leaders to encourage mothers who are pregnant to visit the health care facility as early as the second month so as to ensure that they attend at least four antenatal care visits as recommended by the World Health Organisation. Male spouse participation would be of great significance in ensuring that they facilitate the antenatal care visits and utilisation of health care services.

5.4.2 Sharing of health care information among spouses

There is a need to encourage mothers to share the information they get from antenatal care and postnatal care with their male spouses. This is critical in helping them make a joint decision on where the wife is to attend antenatal care, choice of where to seek delivery facility and for postnatal care. In order to reach the male spouses and encourage their participation in the mothers' utilisation of antenatal care, messages that specifically target and encourages them to participate in the mothers' utilisation of antenatal care should be disseminated. This will enable them understand and find interest in accompanying their

spouses for antenatal care and maternal health care services. The messages could be in form of posters given out through community outreach and also brochures besides the booklets given to mothers when they attend antenatal care. The health workers therefore need to encourage inter-spousal decision making and discussion during sensitisation of the community on the importance of male spouse participation in the maternal utilisation of antenatal care and their influence on infant and young child nutrition and health care services.

5.4.3 Health workers' attitude

In order to encourage both genders to participate in the utilisation of antenatal care services the health care workers should be trained to improve on their attitude towards mothers attending antenatal care and on their public relation and customer care so that they do not harass or mishandle mothers who attend antenatal care, as reported by the later during the FGDs. Suggestion boxes should be established and be placed at the strategic places where the mothers and male spouses would put their comments or suggestions without any fear of being victimised. Complaint registers should be opened in each hospital and customer care desks should be set up to deal with any complaint reported.

5.4.4 Easing of congestion/long queues

Due to the high turnover of patients and mothers seeking antenatal and health care services, the ratio of patients to health care workers is very high thus calling for more staff to be increased through employment to ease congestion and reduce the long queues at the public health care facilities. More health care workers will ease the congestion and long queues by serving the mothers faster thus reducing the time they wait to be attended. Congestion and long queues have been cited as some of the elements that have been discouraging male spouses who could be accompanying their female spouses as they do not like queuing or waiting for long. The county government should employ and remunerate the health care workers well in order to motivate them to improve on the service delivery.

5.4.5 Enhanced gender mainstreaming services/activities at the health facility

The county government should establish gender focal centres within health care facilities that can be used in creating gender awareness and the feedbacks on the community outreach activities. There should be a public participation in provision of health care services through

community health care workers that are aimed at improving the utilisation of antenatal and maternal health care services by both genders.

5.5 Recommendations for further study

A study to establish factors that motivate male spouse participation in antenatal care and in maternal health care services would further strengthen practical and strategic gender needs for the purpose of improving gendered participation in utilisation of antenatal care and maternal health care services.

This study looked into the factors associated with male spouse participation in the utilisation of antenatal care, and their influence in infant and young child feeding in the health centres in Njoro town. These factors are not exhaustive and therefore it is recommended that further study should be carried out to establish more factors influencing male spouse participation in other towns, both in government and private hospitals to find out if they differ.

It is also recommended that further study be done to determine what causes health care workers in government hospitals to relate to mothers in a manner that exhibits rudeness. The factors examined in this study should be subjected to analysis using different methodologies to establish whether the findings will be the same.

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APPENDIX A. RESEARCH PERMIT

NACOSTI

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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25th November, 2014

NACOSTI/P/14/2264/4229

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EGERTON.

DIRECTOR OF HEALTH
NAKURU COUNTY
02 DEC 2014
RECEIVED
P.O. Box 2080-20100, NAKURU.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Participation of male spouses in mothers utilization of antenatal care and their influence on infant and young child feeding patterns, Njoro Town, Nakuru County,"*** I am pleased to inform you that you have been authorized to undertake research in **N akuru County** for a period ending **31st December, 2015.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Coordinator of Health, Nakuru County** 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 rese.arch report/thesis to our office.

SAID HUSSEIN
FOR: SECRETARY/CEO

Noted 2/12/2014
For COUNTY DIRECTOR OF EDUCATION
NAKURU COUNTY

Copy to:

The County Commissioner
Nakuru County.

The County Director of Education
Nakuru County.

National Commission for Science, Technology and Innovation is ISO 9001: 2008 Certified

The County Coordinator of Health
Nakuru County.

Received & Noted
6/1/2015
To report to SCMOH, Njoro.
Kindly give support.
DR LEGAT
CD PITS-NKR

COUNTY DIRECTOR OF HEALTH
NAKURU COUNTY
P.O. Box 2060-20100, NAKURU

Noted. 14/1/2015.
MO I/C, NOI/C Njoro Subcounty Hospital kindly accord him any necessary assistance.
Dr Swaan M. Mitoko
SCMOH.

MEDICAL OFFICER OF HEALTH
NJORO SUB COUNTY
14 JAN 2015
P.O. Box

THIS IS TO CERTIFY THAT:
MR. BARNABAS FRANK ROTICH
of EGERTON UNIVERSITY, 15960-20100
nakuru,has been permitted to conduct
research in *Nakuru County*

on the topic: *PARTICIPATION OF MALE SPOUSES IN MOTHERS UTILIZATION OF ANTENATAL CARE AND THEIR INFLUENCE ON INFANT AND YOUNG CHILD FEEDING PATTERNS, NJORO TOWN, NAKURU COUNTY*

for the period ending:
31st December,2015

.....
Applicant's Signature

Permit No : NACOSTI/P/14/2264/4229
Date Of Issue : 25th November,2014
Fee Recieved :Ksh 1,000

.....
Secretary
National Commission for Science, Technology & Innovation

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No. A 3742

CONDITIONS: see back page

OFFICE OF THE PRESIDENT
MINISTRY OF INTERIOR AND CO-ORDINATION
OF NATIONAL GOVERNMENT

Telegrams: "**DISTRICTER**" Njoro
Telephone: Njoro
When replying please **Quote**

DEPUTY COUNTY COMMISSIONER
NJORO SUB-COUNTY
P.O BOX 500
NJORO

13th January, 2015

Ref. ED.12/10/VOL.I/91

All Assistant County Commissioners
Njoro Sub- County

RE: RE: RESEARCH AUTHORIZATION
BARNABAS FRANK ROTICH

This office is in receipt of a letter Ref. C.C.SR.EDU 12/1/2/VOL.I/111 dated 2nd December, 2014 from County Commissioner Nakuru on the above subject.

This is to inform you that Mr. Barnabas Frank Rotich has been authorized to undertake research on **"Participation of male spouses in mothers utilization of antenatal care and their influence on infant and young child feeding patterns Njoro Sub-county"** He is therefore authorized to undertake research for a period ending 31st January, 2015.

Kindly accord him any necessary assistance he may require to accomplish his research.

P. G. KINYANJUI
FOR: DEPUTY COUNTY COMMISSIONER
NJORO SUB-COUNTY

c.c.

- ✓ *County Commisioner*
  Nakuru County
- ✓ *National Commissioner for ScienceTechnology & Innovation*
  P. O. Box 30623-00100
  Nairobi
- ✓ **Mr. Barnabas Frank Rotich**

OFFICE OF THE PRESIDENT

MINISTRY OF INTERIOR AND CO-ORDINATION OF NATIONAL GOVERNMENT

Telegrams:" DISTRICTER", Nakuru
Telephone: Nakuru 051-2212515
When replying please quote

COUNTY COMMISSIONER
NAKURU COUNTY
P.O. BOX 81
NAKURU

Ref. No. ***C.C.SR.EDU 12/1/2 VOL.I/111***

2nd December, 2014

Deputy County Commissioner,
NJORO SUB COUNTY

RE: RESEARCH AUTHORIZATION - BARNABAS FRANK ROTICH

The above named student has been given permission to carryout research on "***Participation of male spouses in mothers utilization of antenatal care and their influence on infant and young child feeding patterns, Njoro town***" in your Sub County.

Kindly give him the necessary assistance.

NDERITU T.W.
FOR: COUNTY COMMISSIONER
NAKURU COUNTY

APPENDIX B: FOCUS GROUP GUIDE FOR MALE SPOUSES

Male Spouse Participation in Mothers' Utilisation of Antenatal Care in Njoro Town, Nakuru County, Kenya

The researcher, Barnabas F. Rotich of Egerton University's Gender Institute, is carrying out a study on male spouse participation in mothers' utilisation of antenatal care. The researcher would like to know how mothers are working together with their male partners in utilisation of antenatal care services, so as to reduce maternal and child mortality in Nakuru County.

The information gotten from this study will be used for further studies and in designing intervention in mainstreaming gender roles so as to encourage male spouse participation in maternal utilisation of antenatal care. As the researcher, I am requesting you to participate in this research by giving the information that I need. You are free to withdraw from the study at any time. But I am kindly requesting you to take part to the end to make the study successful.

As a participant, I have been told of this study and I understand the objectives of the study as the eventual participation in this study is by choice not coercion. I have understood that I am allowed to withdraw from the study any time I feel like and my withdrawal will not affect my right to access to information and health services in the County.

Participation

Confidentiality and respect for others is assured. Anything you say here will be kept confidential. I will never mention your name outside this room. If you do not want to answer particular questions, that is okay. If you need to leave at any time, that is fine.

Question 1: What do we know about antenatal care, delivery and postnatal care service?

Question 2: Do we accompany our wife for antenatal care, labour and delivery and postnatal care?

Question 3: What reasons prevent men from accompany their wives for antenatal care?

Question 4: How can the health service managers and the health workers encourage male spouse participation in mothers' utilisation of antenatal care services?

Thank you very much for your time to participate in the study.

APPENDIX C: FOCUS GROUP GUIDE FOR MOTHERS

Male Spouse Participation in Mothers' Utilisation of Antenatal Care and in Njoro Town, Nakuru County, Kenya

The researcher, Barnabas F. Rotich a student from the Gender Institute, Egerton University, Njoro, is carrying out a study on male spouse participation in mothers' utilisation of antenatal care and their influence on infant and young child feeding patterns. I would like to know how mothers are working together with their male partners in maternal health services, so as to improve utilisation of antenatal care services by the pregnant women in order to improve on maternal and child health and reduce maternal and child mortality in Nakuru County.

The information gotten from the study will be used for further research and in designing intervention to mainstream gender roles and encourage male spouse participation in mothers' utilisation of antenatal care and their influence on infant and young child feeding pattern. I am kindly requesting you to participate in this research by giving the information that is needed.

As participants, we have been told of this study and we understand the objectives of the study as the eventual participation in this study is by choice not coercion. We have understood that we are allowed to withdraw from the study any time we feel like and our withdrawal will not affect our right to access to information and health services in the County.

Participation

Confidentiality and respect for others is assured. Anything you say here will be kept confidential. We will never mention your name outside this room. If you do not want to answer particular questions, that is okay. If you need to leave at any time, that is fine.

DISCUSSION GUIDLINES

Question 1: Have you utilised antenatal care, delivery and postnatal care services?

Question 2: Discuss the importance of your partner/husband in attending antenatal care, making decision on infant and young child feeding pattern?

Question 3: Discuss on what should be done to improve health facility deliveries and attendance of postnatal care services?

Thank you very much for your time to participate in the discussion.

APPENDIX D: KEY INFORMANT INTERVIEW GUIDE

Male Spouse Participation in Mothers' Utilisation of Antenatal Care Services in Njoro Town, Nakuru County, Kenya

The researcher Barnabas F. Rotich is a student of the Gender Institute, Egerton University, Njoro campus, is carrying out a study on male spouse participation in mothers' utilisation of antenatal care services. The purpose is to know how male spouse are working together with their female partners in maternal health services, so as to improve utilisation of antenatal care services by the pregnant women in order to reduce maternal child mortality in the County given that the health services have been devolved as per our Constitution.

The information gotten from this study will be used as new information that will guide in gender mainstreaming of reproductive health roles so as to improve on the male spouse participation in antenatal care services, infant and young child feeding pattern and also help in designing intervention programmes.

Thank you.

Participation

Confidentiality and the respect of your office or institution will be uphold or adhered to. Anything you say here will be kept confident and for the purpose of this study.

Question 1: What could be the possible reasons hindering men in Njoro town from participating in their wives' utilisation of antenatal care, delivery and postnatal care from your own assessment and observations?

Question 2: Discuss on what should be done to improve male spouse participation in mothers' utilisation of antenatal care and their influence on infant and young child feeding pattern?

Question 3: What should be done to improve utilisation of antenatal care, delivery and postnatal care services given that such services have been devolved in the new dispensation?

Thank you very much for your time and information.

APPENDIX E: QUESTIONNAIRE

Dear Sir / Madam,

I am a student undertaking a Master's degree in Women, Gender and development Studies and am seeking to find out the participation of male spouses in mothers' utilisation of antenatal care and their influence on maternal utilization of antenatal care services. The findings will be used to develop strategies towards the attainment of Millennium Development Goals number 4 and 5 and Vision 2030 Medium Term Plan II on health care which seeks to improve the overall livelihood of Kenyans through provision of efficient and high quality health care at the village and county level. Please answer the following questions as honestly as possible. All the information given will be treated with the highest confidentiality and will be used for academic purpose only. Participation is on voluntary basis. Kindly, sign below as an indication of your consent to participate on this study.

Thanking you in advance for your cooperation.

Signature……..

Barnabas F. Rotich.

Principal Researcher

Informed Consent

Name……..Date…….

Signature…….

Instructions

This questionnaire will help the researcher to understand the level of Male spouse participation in the utilization of antenatal care and their influence in maternal utilization of antenatal care services. The information you give will be highly confidential so please answer all the questions appropriately and sincerely.

Use a Tick to select the appropriate answer.

SECTION A: Background Information **Questionnaire No_____**

Please answer all the questions (fill the blanks) **Date of Interview_____**

S/N	INDICATORS DATA	FEMALE SPOUSE
1	Age of respondent (please indicate years)	
2	Place of residence	
3	Education level 1. Primary 2. Secondary 3. Tertiary 4. University	 _____ _____ _____ _____
4	Occupation	
5.	Religion 1. Christian 2. Muslim 3. Traditional 4. Atheist	 _____ _____ _____ _____
6.	Ethnicity	
7.	Marital status 1. Married 2. Contractual 3. Single 4. Widowed 5. Separated 6. Divorced	 _____ _____ _____ _____ _____ _____
8.	Number of children born to the mother	
9.	Total number of pregnancies to the mother	

S/N	INDICATORS DATA	FEMALE SPOUSE
10.	Number of living children	
11.	Have you heard of antenatal care services before? 1. Yes 2. No	 _____ _____
12	Distance to the health facility Less than 5km More than 5km	 Yes_____No_____ Yes_____No_____
13	Name source of information or knowledge on antenatal care (tick relevant response) 1. Relatives 2. Friends 3. Books 4. Media 5. Church 6. Health worker	 _____ _____ _____ _____ _____ _____

Section B: mothers' utilisation of antenatal care services. Please fill the appropriate Space (___)

14. Who initiated the antenatal care visits during your last pregnancy?

1. Male spouse_____

2. Female spouse_____

3. Both partners____

15. Who decided on the health facility to visit for antenatal care, delivery and postnatal care in the last pregnancy?

1. Male spouse_____

2. Female spouse_____

3. Both partners_____

16. Who made the decision on the delivery health facility?

1. Female spouse _____

2. Both spouse_____

3. Male spouse_____

17. Is it the same facility visited for antenatal clinic?

1. Yes_____

2. No_____

18. If your answer to the above question is No, please give reason why? _____

19. Did your spouse give you support for fare?

1. Yes____

2. No_____

20. Did your spouse accompany you during the delivery?

1. Yes_____

2. No_____

21. If yes, did he enter with you to the labour ward/room?

1. Yes_____

22. Have you ever consulted a traditional birth attendant (TBA?)

1.Yes_____

2. No_____?

23. If yes, please explain briefly why? _____

Section C: Male Spouse support on mothers utilisation of antenatal care. Please fill the blank space (____)

24. How many antenatal care visits did you attend during you last pregnancy? ____

25. Did your spouse accompany you in any of the visits?

1. Yes____

2. No_____

26. If yes, in how many antenatal care visits were you accompanied by your spouse? _____

27. If not accompanied, did you inform him on the antenatal clinic outcome?

1. Yes___

2. No____

28. If your answer is No, briefly explain why? _____

29. Did your spouse provide any assistance in taking care of your nutrition during and after postpartum?

1. Yes___

2. No_____

30. If yes to the above question, what form of assistance?

1. Assist in household chores_____

2. Watching over other children_____

3. Cooking or warming the food _____

31. What support did your spouse offer to you when you were attending post natal care?

1. Buying the foods and other necessities__

2. Hiring a household help___

3. Providing fare for postnatal visit___

4. Accompanying for postnatal care visit___

32. Does your culture prohibit you from participating in infant and young child feeding decision?

1. Yes_____

2. No___

33. If yes please specify_____

Thank you for taking time to answer the above questions.