DETERMINANTS OF MALE INVOLVEMENT IN THE UTILIZATION OF MATERNAL AND CHILD HEALTH SERVICES IN LAMU COUNTY

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DECLARATION

This research project report is my original work and has not been submitted to any other College, Institution or University.

Signed: _____ Date: _____

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This project has been presented for examination with my approval as the appointed University Supervisor

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DEDICATION

I dedicate this study to my son Ted and my sister Eunice for their unrelenting support during my study period.

ACKNOWLEDGEMENT

I would like to express my sincere gratitude to all those who contributed in their own special and different ways during my whole study period. Special thanks go to my supervisor, Prof. Gakuu for his support and valuable comments from the design of the project proposal to the completion of the study report. I further wish to acknowledge the University of Nairobi for granting me the opportunity to pursue this degree. I thank all the Lecturers who have contributed in their own ways in seeing me this far. I thank my entire family for their support and encouragement during my study, and my colleagues and friends for their encouragement.

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LIST OF ABBREVIATIONS

ACT Artemisin Combined Therapy

AMREF African Medical and Research Foundation

ANC Antenatal Care

CRA Commission on Revenue Allocation

CPR Contraceptive Prevalence Rate

CSO Civil Society Group

CBO Community Based Organizations

FANC Focused Antenatal Care

FGD Focused Group discussions

GID Gender in Development

ICPD International Conference on Population and Development

IMCI Integrated Management of Childhood Illnesses

ITNs Insecticide treated Nets

KDHS Kenya Demographic Health Survey

MDGs Millennium Development Goals

MCH Maternal and Child health

PMCH Partners in Maternal, Newborn and Child Health

PMTCT Prevention of Mother to Child Transmission of HIV/AIDs

SBA Skilled Birth Attendant

SSA Sub-Saharan Africa

UNPFA United Nations Population Fund

WID Women in Development

WHO World Health Organization

ABSTRACT

Male involvement has been blamed for the poor utilization of health care services across the globe. This study sought to establish the determinants of male involvement that influence the utilization of maternal and child health services in Lamu county. It was guided by five objectives: To establish the social cultural factors that influence utilization of maternal and child health services, to assess the economic factors that influence male involvement in the utilization of maternal and child health services, to assess the demographic factors that influence male involvement in the utilization of maternal and child health services, to establish how the attitudes of health workers affects male involvement in the utilization of maternal and child health services and to examine the opinions of community members as regards to male involvement in the utilization of maternal and child health services in Lamu county. The research employed a qualitative descriptive design. Data was collected in June 2013 through use of focused group discussions, key informant interviews and in depth interviews .Multi- stage sampling was used to sample the health facilities with a complete list of all health facilities as the first level and a list of the 10 busiest facilities as the second level. Purposive sampling technique was used to select 4 health facilities with the highest MCH visits in the county, the community leaders and to select the health workers for the study. Typical case sampling was used in selection of men accompanying their women to the MCH clinics. Homogeneous sampling was used in selection of men and women for the focus group discussions from the health facility catchment area.Tape recorded interviews were first transcribed verbatim before content analysis was undertaken. The study established that the community perceptions and the strong cultural and gender norms, coupled with financial constraints play a key role in men that prevent them and their families from utilizing the MCH services offered in the health facilities. In addition, health worker behavior and the long waiting time in health facilities bars men from such facilities. The study further found out that religion, age, level of education and profession of the men play a key role in determining their involvement in the utilization of MCH services in Lamu county.The study recommends that policy makers and stakeholders in general should strive to mainstream male involvement in MCH programming and move away from the traditional approaches of MCH which placed the man at the periphery of reproductive health programmes. This should be supported with stronger policies in place which will be implemented at all levels of health care, from the community to the higher levels of care for them to succeed**.**

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Until the late nineties', reproductive health programmes focused entirely on women, viewing men as non actors whose role was regarded as irrelevant (Kakaire et al., 2011), an observation further alluded to by (Kukulanga et al., 2012), who point out that maternal health issues have traditionally been treated as a feminine matter that men were less concerned about. This has led to poor male participation in maternal health care services. In addition, men have for a long time been ignored or believed to be the stumbling blocks when it comes to the health of their partners (Nwokocha, 2007). It was not until the International Conference on Population and Development (ICPD) of 1994 held in Cairo, Egypt and the Fourth World Conference on Women held in Beijing in 1995 that the role of men in reproductive health was greatly emphasized (Becker and Hindin, 2007). It was during this period that a proposal was made that men should be involved in the care of their partners since their participation in maternal and child health care was critical to the improvement of MCH indicators and the empowerment of women as a whole.

Many definitions have been put forward as to what comprises male involvement in maternal and child health (MCH) care services utilization. Bhatta and Dharma (2013) have tried to define male involvement as men attending antenatal clinics (ANC), participating in developing individual birth plans, encouraging exclusive breastfeeding and taking part in scheduled immunization schedules for their children, a definition which has largely been accepted though a few critics believe there is much more than just these areas.

A number of studies carried out in various part of the world have shown the significant roles that men played especially in decision making in regards to maternal, newborn and child health issues, that limits women's access to their choices during pregnancy and child birth (Kinanee and Hart, 2009). In his study, Chiwuzie (2007) points out that men are roadblocks to achieving optimal health for women during pregnancy and childbirth, a point which has been discredited by (Katz et al.,2009) who asserts that husbands positive

involvement brings out positive outcomes for both the mother and the child . Katz et al,(2009) point out at some of the positive male inclusion in MCH issues such as taking the wife to a skilled attendant, providing financial support to the health facility and emotional as well as physical support throughout the pregnancy and child birth. A study carried out in Nepal brings out a complex issue where men are discouraged from participating in MCH services and forums (Brunson, 2010) whereas lack of knowledge about MCH posed a great challenge to the men who were eager to get involved in the pregnancy and child birth issues of their wives (Mullaney, 2006). In his study, Chattopadhyay, (2010) established that men's knowledge about MCH and their presence and participation during antenatal care visits were related to use of skilled attendants during delivery and a positive outcome of the pregnancy. Studies from India and Nepal; have indicated that male involvement in MCH services is crucial for maternal health services utilization (Chattopadhyay, 2012). Cultural aspects in India and sub Saharan Africa have a strong bearing on family matters and this has further been complicated by the patriarchal nature of these communities which leave women's' health to be almost solely dependent on them due to their limited educational and economic opportunities (Mullaney, 2006).

A study carried out in Kenya between 1999 and 2005 found a strong correlation between low male participation in MCH services where prevention of mother to mhild transmission of HIV (PMTCT) services are offered and a mother to child transmission risk in exposed infants (Farquhar et al., 2004). Bhatta and Dharma (2013) further allude to the fact that men hold key positions that give them the socio-economic powers and control over their spouses that affects their engagement in all spheres of life including in MCH services utilization. He further points out that it is men who decide on timing and conditions of sexual relations, family size, and whether or not their spouses will utilize available health care services. Internationally, calls to include and involve men in the maternal and child health care have been made in various forums and in many country specific policy documents (WHO, 2007). They point to the need of inclusion of men in all spheres of women empowerment forums if the holistic gains are to be realized. This is because failure to do so is at best a partial solution which at its worst would create more

conflict leading to more problems since they would increase men's' feelings of alienation. However, the level of male involvement and engagement during pregnancy and child birth in many African homesteads and communities still remains elusive and a subject of debate (Williams et al., 2010).

1.2 Statement of the problem

There is an increasing recognition globally that the involvement of men in MCH programmes and service delivery offers both men and women, and the family in general important benefits (WHO, 2007). Such benefits have included but not limited to good health, better learning skills on the part of the children, happier and healthier families and more productive communities and the nation in general (Mullaney, 2006). In addition, involving men in programmes targeting women and children could help countries achieve Millennium Development Goals (MDGs) 4 and 5 faster than is currently projected in many developing countries (Nwokocha, 2007).

According to a baseline survey carried out by the African Medical and Research Foundation (AMREF, 2010), maternal and child health indicators in Lamu remain poor. The base-line study revealed a low knowledge of family planning methods among women of reproductive ages (15-49) at 70.6 percent in Lamu county compared to the national figure of 95 percent(KDHS ,2008/09). Only 35.8 percent of the mothers in the project area met the FANC requirement of 4 episodes of antenatal care visits during their last pregnancy. Over half (50.9 %) of the sampled mothers in the county did not meet the FANC target as they visited antenatal clinic 1-3 times during their entire pregnancy. Further, the base-line reported that only 14.7 percent of the mothers commence their ANC within the 1st trimester of pregnancy while 70.2 % started their ANC visits during the second / third trimester (4-6 months) of pregnancy.

The baseline study further revealed that skilled birth attendance was low in the county with 58.8 percent of deliveries in the county still occurring at home under the watch of unskilled traditional birth attendants (AMREF, 2010).

Using measles as the proxy indicator for vaccination coverage children who had completed all their scheduled vaccinations, it can be deduced that vaccination coverage in Lamu District is at 81 percent with nearly 20 percent of children under five years of age not immunized against common childhood diseases. This figure is lower than the national measles coverage of 85 percent (KDHS 2008/09).

While there are other factors that may contribute to these poor indicators, the role of male involvement stood out very clearly as an area that has big role in influencing maternal and child health seeking behavior, a factor that ought to be investigated. This study therefore sought to establish the determinants of male involvement in the utilization of maternal and child health services in Lamu county that has a bearing on the maternal and child care outcomes.

1.3 Purpose of the research

This study aimed to establish the determinants of male involvement in the utilization of maternal and child health services in Lamu county of Coastal Kenya.

1.4 Objectives of the study

The objectives of the study were:

1. To establish the socio-cultural factors that influence male involvement in the utilization of maternal and child health services in Lamu county
2. To assess the socio-economic factors that influence male involvement in the utilization of maternal and child health services in Lamu county
3. To assess the socio-demographic factors that influence male involvement in the utilization of maternal and child health services in Lamu county
4. To establish the health service related factors that influence male involvement in the utilization of maternal and child health services in Lamu county
5. To assess the perceptions of community members as regards to male involvement in the utilization of maternal and child health services in Lamu county

1.5 Research Questions

The following were the research questions that this research sought to answer:

1. What are the socio-cultural factors that influence male involvement in the utilization of maternal and child health services in Lamu county?
2. What are the socio-economic factors that influence male involvement in the utilization of maternal and child health services in Lamu county?
3. What socio-demographic factors play a role in determining the involvement of men in the utilization of maternal and child health services in Lamu county?
4. Are there health service-related factors that affect the involvement of men in the utilization of MCH services in Lamu county?
5. Do perceptions of community members affect male involvement in the utilization of maternal and child health services in Lamu county?

1.6 Significance of the Study

In the past, researchers in the field of maternal and child health have focused almost exclusively on women and children when planning for health programmes and services without involving their spouses, the men. This study sought to provide information for policy makers and identify programming gaps on male involvement to stakeholders especially the Ministry of Health, development partners and civil society organizations (CSO) and to recommend strategies to improve the same. This study contributes to the body of knowledge for both researchers and academicians acts as a reference for future research. The outcome of this research serves as a basis to which advocacy for male involvement in MCH should be pegged as well as to inform national level decision making in Kenya as regards to MCH.

1.7 Study Limitations

The study was limited by its descriptive nature and a small sample size and as such, findings may not be generalizable to the larger population in the country. However, qualitative approaches in methodology enabled an in-depth understanding of the phenomena under study.

1.8 Delimitation of the study

To overcome the above limitation, the researcher used data triangulation in order to increase the validity of the study whereby different sources of information were used in order to enable an in-depth understanding of the phenomenon under study. In addition and in order to ensure data quality and reliability, research assistants were selected among the Lamu county population where the study was conducted. Key informant and FGD guides were translated into simple understandable Swahili Language that the communities speak and understand. Research assistants were trained on how to facilitate discussion, ask questions, take notes and establish good rapport while working with the community. Tools which were used were first pre-tested in the same population during the research assistants training. Daily debriefing meetings with research assistants were held after data collection which sought to solve problems raised during field work.

1.9 Assumptions of the Study

The study made some basic assumptions that the sample would be representative of the population, that the study respondents would be responsive to the questions and would give true answers on the aspects of maternal and child health seeking behaviors being sought and that the data collection instruments were valid. This was verified during the pre testing of the research instruments.

1.10 Definition of Significant Terms Used in the study

Male involvement: Men attending antenatal clinics (ANC) with their spouses, participating in ANC lessons including developing individual birth plans, accompanying their spouses during labor and child birth, and taking part in scheduled immunization schedules for their children

Maternal and child health services: Various facilities and programs organized for the purpose of providing medical and social services for mothers and children under five years. These include antenatal and postnatal care services, family planning care, labour and child birth services, immunization and growth monitoring

Skilled Birth Attendant: An accredited health professional, such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage pregnancy and childbirth and child health care services

Utilization of Maternal and child health care services: Making use of the maternal child health care services provided in the facilities

Health Service: A public service that is responsible for providing medical care.

Health Facility: A facility that provides health care services.

1.11 Organization of the study

Chapter one of this study gives an overview of the maternal and child health issues globally with an emphasis on Africa and Kenya. The chapter outlines research questions as well as objectives that guide this study. The following areas have been highlighted by the chapter: the research problem, purpose of the study, objectives of the study, research questions, and significance of the study, study assumptions, limitations, de-limitations and definition of significant terms.

Chapter two reviews existing literature on the issue of male involvement in MCH and goes further to look at the different factors that have been attributed to affect male involvement in MCH and their implications in influencing MCH in various parts of the globe. The chapter further describes the conceptual framework that highlights the variables that formed the foundation of the study.

Chapter three gives the research methodology and highlights the design that was used, data collection, processing and analysis. The chapter briefly describes the target population as well as the sampling methods that were are used in the study.

Chapter four presents the study findings in which the findings of each study objective is outlined and described in themes

Chapter five presents the study findings in summary, gives a discussion of the same and conclusion. This chapter gives a contribution of the study to the body of knowledge and

recommendations both to policy makers, civil society players in the MCH sector as well as other researchers.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter covered the outline of literature from previous writings and documents that were reviewed. This chapter starts by giving a synopsis of male participation or non participation thereof, demonstrating the factors that have been studied from various parts of the globe that relate to the non- involvement of men in maternal and child health care services. It concludes by tying together the factors that seem to come to play, forming the conceptual framework of the study.

2.2 Male Involvement in Maternal and Child Health care

Male participation in reproductive health has proved to be challenging in countries where there are culturally defined gender roles and where manifestations of masculinity involve violence against women, alcohol consumption, and high-risk sexual behaviours (Onyango et al., 2010). In most communities in Africa, men still have a dominant role in reproductive health-related issues. A number of decisions, such as sexual initiation, contraceptive use, whether to have an abortion, prevention and treatment of sexually transmitted infections (STIs) and HIV, sexual coercion, still depend on men. A study conducted in a northern Ghana community revealed that introduction of family planning services brought tensions in gender relations within the community (Nwokocha,2007). Women were worried that their husbands and relatives would find out about their use of contraceptives, while the men believed that they alone should make decisions about their partners' contraceptive choices (Nwokocha, 2007).

In many African settings, male involvement has been minimal and this has been attributed to the high maternal and child morbidities and mortalities that occur in most of these settings (Reece et al., 2010). To date, the issue of pregnancy and childbirth and to some extend child rearing has been viewed solely as a woman's affair (Magoma et al., 2010). This is because women are the ones who get pregnant and give birth. Men were regarded as the problem, seen as uncaring and unconcerned parties that needed to be

evaded if women's overall health during pregnancy and child birth were to be optimally achieved (Kululanga et al., 2012). This erroneous exclusion of men in MCH service utilization has been disapproved and it is now agreed that women's access and utilization of MCH services depends on their partners, the men (Mullany, 2010). Dharma and Bhatta (2013) further allude to the fact that men hold key positions that give them the social and economic powers and control over their spouses that affect their engagement in all spheres of life including in MCH services utilization. The study further points out that it is men who decide on timing and conditions of sexual relation, family size, and whether or not their spouses will utilize available health care services.

In his study, Chiwuzie (2007) points out that men continue to be roadblocks to achieving optimal health for women during pregnancy and childbirth, a point further discredited by (Katz et al.,2009) who assert that husbands' positive involvement brings out positive outcomes for both the mother and the child. In addition, (Kukulanga et al., 2012) point out at some of the positive male inclusion in MCH issues as taking the wife to a skilled attendant, providing financial support to the health facility, emotional as well as physical support throughout pregnancy and child birth.

In his study, Chattopadhyay, (2010) established that men's knowledge about MCH and their presence and participation during antenatal care visits were related to the use of skilled attendants during delivery and a positive outcome of the pregnancy. Studies from India and Nepal have indicated that male involvement in MCH services is crucial for optimal child and maternal health care services utilization (Chattopadhyay, 2010).

A study conducted at Kenyatta hospital and Kakamega provincial hospital in Western Kenya concluded that men do participate in MCH services to some extent. The majority of men accompany their wives to the hospital if there are fees to be paid, for obstetric/gynaecological consultations, delivery, and antenatal care (Muia et al., 2010). None of these studies have looked at factors that influence male involvement in MCH and the best approaches to including men beyond the physical accompaniment to the health facility. In another study carried out in Kenya between 1999 and 2005, the researchers found a strong correlation between low male participation in MCH services

where Prevention of Mother to Child Transmission of HIV (PMTCT) falls and the high Mother to Child Transmission risk in exposed infants (Mulany, 2010).

It has also been widely agreed that the leading causes of maternal deaths are the three key delays some of which are linked to men, the key decision makers in most of the African set ups. The influence of men in decision making has been shown in many MCH studies but there still exists scarcity of information as relates to men's' intentions and practices as they relate to pregnancy and child birth especially in Asia and sub Saharan Africa, (Nkuoh et al., 2010). Studies have showed that men have not only continued to act as gatekeepers that restrict women and children access to health services but have also played a key role through gender based violence and neglect (Chiwuzie, 2007). These have far reaching implications on the health of women and their children (Kululanga et al., 2012). The first delay, the delay to decide whether to seek health care has been blamed on poor male involvement and the patriarchal nature of many African homesteads. This is because men are the decision makers and the controllers of the family resources and hence their involvement is critical (Babalola and Adesegun, 2009).

Internationally, calls to include and involve men in the maternal and child health care have been made in various forums and in many country specific policy documents (WHO, 2007). They point to the need of inclusion of men in all spheres of women empowerment forums if the holistic gains are to be realized since the failure to do so is at best a partial solution which at its worst would create more conflict leading to more problems since they would increase men's' feelings of alienation. However, the level of male involvement and engagement during pregnancy and child birth in many African homesteads and communities still remains elusive and a subject of debate (Williams et al., 2010).

2.3 Studies on Male Involvement in MCH services utilization

A number of studies carried out in various part of the world have shown the significant roles that men play especially in decision making in regards to maternal and child health issues, that limits women's access to their choices during pregnancy and child birth (Kinanee and Hart 2009). Reproductive health practitioners have recognized that the

failure to target men in MCH programmes have weakened the impact of such programmes and led to limited results (Kakaire et al., 2011). In their study, (Iliyasu et al., 2010) allude to the fact that men can significantly influence MCH outcomes and the long term impact of reducing morbidity and mortality if they are involved in the whole continuum of care, prenatally through to the post natal period and beyond. A multiplicity of factors have been alluded to in many studies that to a great extend influence the utilization of MCH services by men and their much needed support to their spouses and children in MCH health seeking behaviors(Ditekemena et al.,2011).

2.4 Demographic factors as influencers of male involvement in MCH services utilization

Studies have linked a variety of socio-demographic factors and male participation in maternal and child health care. Factors such as the age of men, their marital status and their level of education have been linked to the level of male involvement in the care of their families especially as relates to pregnancy and childbirth and the care of their children (Bhatta & Dharma 2013). Most of these studies have reported that older married or cohabiting men were more likely to participate in the care of their spouses and their children as compared to the younger men (Ditekemena et al., 2011). A study carried out in Congo established that married men in monogamous unions were more likely to be involved in the MCH care as compared to those in polygamous unions (Ditekemena et al, 2011). The level of education of men has also been found to be a factor that influences that level of involvement of men in influencing the health seeking behavior of their spouses. A study carried out among Ugandan men established that men who had completed eight or more years of education were more likely to be involved in the care of their spouses as compared to those with less years of schooling (Byamugisha et al., 2010).

2.5 Socio-Cultural factors and male involvement in MCH services utilization

Several studies carried out in various parts of the globe and Africa have identified cultural beliefs that act as barriers for male involvement in MCH services (Mulany, 2010). Cultural aspects in India and sub Saharan Africa have a strong bearing on family

matters and this has further been complicated by the patriarchal nature of these communities which leave womens' health to be almost solely dependent on them due to their limited educational and economic opportunities (Mullaney, 2006). In their study, (Nkuoh et al., 2010) further allude to the fact that religion in some cultures such as the Muslim culture limits female mobility and since most doctors in these Asian cultures are male, women do not want them to be present during childbirth (Ahmed and Jakaria, 2009). It has also been noted that better spousal communication may in a way improve women's' maternal health care seeking behaviors' (Mullany, 2010) and that spouses attitudes and beliefs can play a key role in overcoming access barriers to MCH care or conversely, act as barriers themselves (Chiwuzie, 2007).

These coupled with the more complex gender power relations which arose as a result of the reorientation of women in Development programmes (WID) into gender and development programmes (GAD) which caused a rethinking as regards to male participation in health care and health promotion in their homesteads has not made it easier for male involvement in MCH care (Nkuoh et al., 2012 & Chiwuzie, 2007). Although these programmes were further strengthened with the inclusion of male involvement of men in the Cairo conference platform as critical pillar for achieving optimal reproductive health, they still pose serious questions about the effects of including them in areas traditionally considered the preserve of women (Nwokocha, 2007).

It is almost unheard of in many settings in Sub- Saharan Africa to see men accompanying their partners to the antenatal clinics or even in the delivery room due to the strong cultural misconceptions revolving around their involvement and participation in maternal and child health care (MCH) amongst them social and religious norms and the wide spread attitude that MCH is not a male responsibility (Byamugisha et al., 2010). In their study, (Kakaire et al., 2011) assert that programmes that seek to improve maternal and child health should target to improve male involvement during pregnancy and childbirth- including but not limited to making men key respondents in birth preparedness and utilization of maternal and child health care services provided.

Culturally sanctioned gender norms and the traditional ways of implementing RH programs were also found to influence male involvement in reproductive health (Onyango et al., 2010).

2.6 Health services factors as determinants of male involvement in MCH services utilization

A variety of factors revolving around the health care workers in the MCH clinics have also been found to play a key role in determining the utilization of MCH services by men. Such have included the harsh critical behavior and language use that they receive from the health workers in these facilities (Ditekemena et al., 2011). A study carried out in Uganda established that the harsh language used by the health workers was a barrier to male participation. Further,some of the health workers did not allow men to access the ANC settings and as such discouraged men from accompanying their spouses to the same (Byamugisha et al., 2010).This observation has further been alluded to by (Nkuoh et al., 2012) who have pointed at the big role that care givers played in promoting or dissuading male participation in the utilization of MCH services.

The long waiting time in the health facilities has also been pointed out as a factor that bars men from accompanying their spouses to the MCH clinics. This has been linked to the long and cumbersome administrative procedures that result in poor client through-put in health facilities. This pushes men away since they cannot afford to spend the entire day participating in the clinics at the expense of their jobs (Byamugisha et al., 2010). Another interesting factor that has been attributed to the low male involvement in MCH services especially ANC and immunization services are the timing of these services. (Ditekemena et al., 2011) established that men were not able to participate in these services since most of them were working in the morning hours and most of the men could not afford to leave their workplaces to accompany their spouses (Bwambale et al., 2008).

A study carried out in Nepal brings out a complex issue where men are discouraged from participating in MCH services and forums Brunson (2011) whereas lack of knowledge about MCH posed a great challenges to the men who were eager to get involved in the pregnancy and child birth issues of their wives (Mulany, 2010).

2.7 Economic factors linked to male involvement in MCH services utilization

In addition, economic factors seem to play a key role in influencing the involvement of men and their participation in the care of their spouses during pregnancy and child birth. Taxi drivers and boda boda riders in Uganda were found to be less involved in the MCH services due to the nature of their jobs as compared to their counterparts such as farmers (Byamugisha et al., 2010). This has further been supported by (Reece et al.,2010) who in their study have alluded that men with casual jobs were less likely to participate in MCH services in Kenya as compared to those with permanent jobs. This observation has further been made by (Kowalczyk et al.,2012) who in their study found out that those men in well paying and permanent jobs in Rwanda were more likely to be involved in MCH services utilization with their spouses. Men who were more economically empowered tend to be more involved in MCH services utilization as compared to their counterparts who are struggling to make ends meet for their families (Byamugisha et al., 2010). Other financial constraints such as cost to the health facilities as well as user fees have been pointed out in studies as contributing to the underutilization of MCH services by men (Bwambale et al., 2008).

2.8 Community perceptions regarding male involvement in MCH services utilization

Community perceptions and opinion regarding men who were involved in MCH services utilization beyond the household have contributed to the low male involvement in MCH. Some men are embarrassed to be seen in ANC clinics which have for a long time being perceived as a female place while some men fear they will be perceived as dominated by their wives (Mlay, 2008 & Mulany, 2010). In a study carried out in Western Kenya, several negative perceptions towards men participating in MCH services were reported which posed series challenges to the promotion of male involvement with those men accompanying their spouses to the ANC for instance being perceived as cowards or ‘not men enough’’(Onyango et al.,2010).

2.9 Conceptual Framework

A conceptual framework is a representation of the concepts in a study sometimes done diagrammatically to provide a clear picture of the variables to be explored in the study

(Rees,2007, Polit & Beck, 2012). Additionally, a conceptual framework in research studies is a useful guide on what should be included in the tool of data collection and may guide the study's discussion (Rees, 2007)

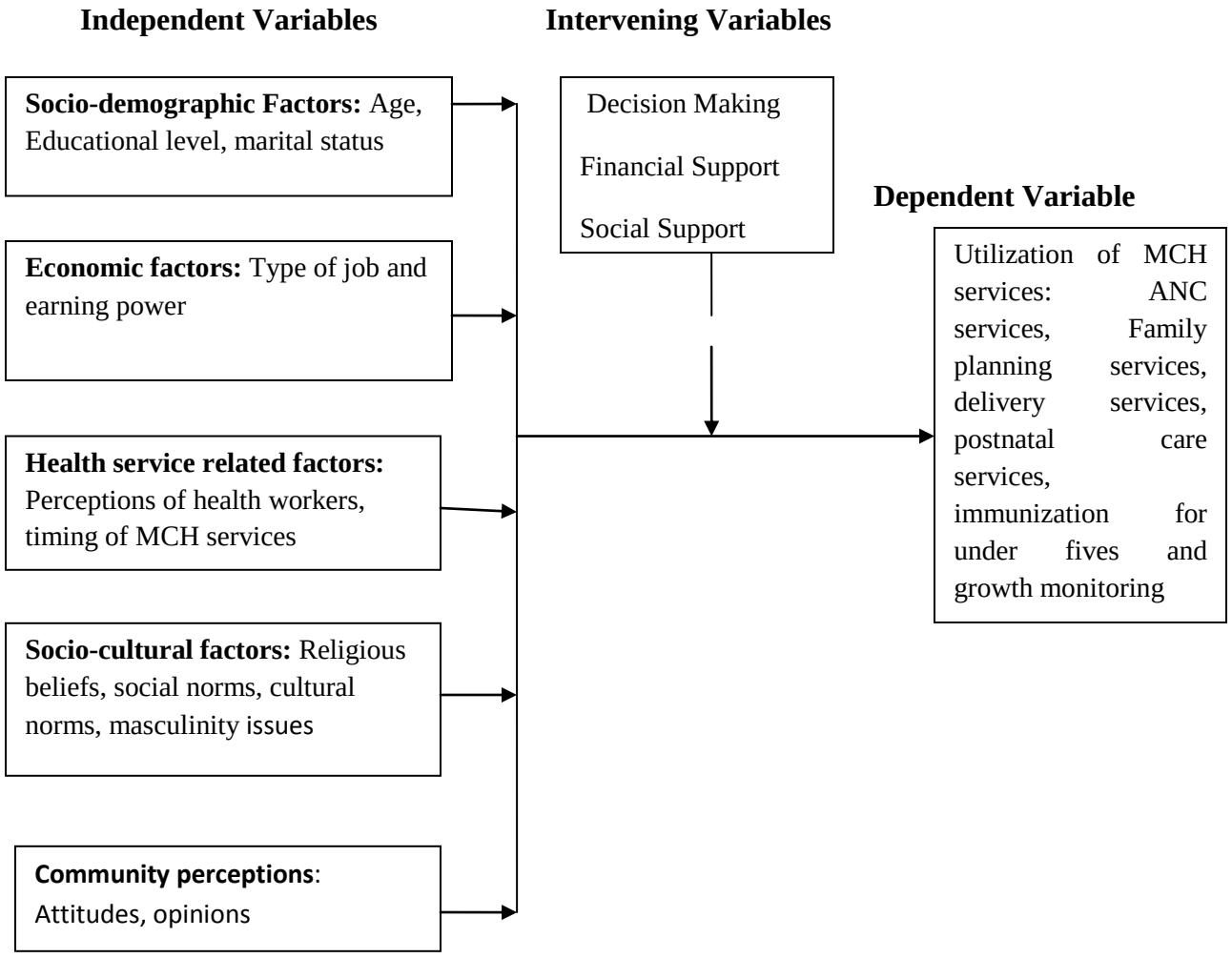

Figure 2.1: Conceptual framework

The various variables highlighted in the conceptual framework are discussed herein below. These provide an all encompassing understanding of the study and help to guide the direction of the study.

Social-Demographic Factors: These refer to the age, the educational levels and the marital status of the man. These factors have been linked to the level of involvement of men in the care of their families especially as relates to pregnancy and childbirth and the care of their

children. Older men with a high educational level up to tertiary level, and in stable marriages have been observed to be more involved in the care of their spouses and children as compared to their younger, less educated and 'come we stay' marriages (Ditekemena et al., 2011).

Economic factors: These refer to the earning power of the men, the types of jobs the men do and their ability to pay for the MCH services. These have been found to dictate the involvement of men in MCH service utilization in various ways. Such have included the ability to get time off to accompany their spouses to the health facility, the ability to afford user fees to pay at the MCH facilities, the and the ability to ensure that their families lead a healthy life (Byamugisha et al.,2010).

Health service related factors: Perceptions of health workers towards men who accompanied their spouses to the health facilities, the language they use and the way they treat them during service delivery to their spouses has been found to contribute positively or negatively to the level of male involvement in MCH (Byamugisha et al., 2010) in addition, timing of MCH services has also been linked to the lack of male participation, with many men opting out due to the fact that MCH service hours collided with their working hours in many instances (Bhatta& Dharma,2013).

Socio-cultural factors: These refer to culturally sanctioned beliefs and social norms which is gender biased and determined by the society and which play a massive role in influencing the behavior of men in MCH. Others have included males' attitudes and beliefs which have been based on their socialization. Religious beliefs are equally blamed for the poor involvement of men in MCH issues.

Community perceptions: Attitudes and opinions of community members (both men and women) have also being blamed for lack of involvement of men in the utilization of MCH services. This has been in the way the community perceives and treats men who are involved in what is culturally perceived as women territories (Kukulanga et al., 2012) and the behavior towards those who are seen to take part in MCH services utilization.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter contains the adopted research design, the data collection methods used and the methods of data analysis adopted by this study. It is dedicated to the description of the methods and procedures that were used in order to obtain the data, how the data was analysed, interpreted, and how the conclusion was drawn.

3.2 Research Design

A research design is a program that guides the investigator in the process of collecting; analyzing and interpreting observations (Taylor et al., 2007).This research employed a qualitative descriptive study design that aimed to establish the determinants of male involvement in the utilization of MCH services in Lamu county of Coastal Kenya. Qualitative research emphasizes the central role of the research context and people in generating knowledge that is personal and practical, and which comes from the perspective of people engaged actively in their lives. It values what people have to say about how they feel, what they believe and think, based on whatever information they have amassed as respondents in experiencing life (Taylor et al., 2007). The phenomena under study thus required a thorough interrogation to unearth peoples lived experiences as regards to male involvement in MCH and the determinants of the same within their context.

3.3 Target Population

The study was undertaken in Lamu County, which is located in the northern coast of Kenya. Lamu county borders the following counties; Garissa to the North, The Indian Ocean to the South and South East, and Tana River to the South West and West. According to the 2009 national census, Lamu has a population of 101,539 people with 52% of the population being men while the rest 48% of the population are women (Commission on Revenue Allocation, 2011).

3.4 Sampling design

A sample is defined as a subset of a population which refers to the total population about which information is required (Hani, 2009). It comprises of some members of the population. Sampling is the process of selecting sufficient elements from the population so that the study of the sample and an understanding of its properties would enable us generalizes such properties to the population elements. The sample unit of the study was the health facility. In this study multistage sampling was employed in order to achieve the study objectives.

3.5 Sampling Technique

Multi-stage sampling was used to sample the health facilities for the study with a complete list of all the 38 government health facilities as the first level and a list of the 10 busiest facilities at the second level. Purposive sampling technique was used to select 4 health facilities with the highest MCH visits in the county per month. Hindi Dispensary, Mpeketoni Sub district Hospital, Kizingitini Health Centre and Hongwe Dispensary were selected for the study. Mokowe Health Centre was used for pre-testing of the tools.

Women with children under five years of age together with their spouses were the third level. Typical case sampling was used in selection of men accompanying their women to the MCH clinics. A trained research assistant was stationed at the selected study facilities for one day each to interview the men accompanying their spouses as well as the women. 5 men and 5 women were sampled for the in-depth interviews with 2 of the men being health workers from the clinics and 2 being female heatlh workers while the rest were clients visiting the MCH clinics.

Homogeneous sampling was used in selection of men and women for the focus group discussions from the 4 health facilities catchment area. A homogeneous sample is one in which the researcher chooses respondents who are alike. Homogeneous sampling is of particular use for conducting focused group discussions because individuals are generally more comfortable sharing their thoughts and ideas with other individuals who they perceive to be similar to them (Patton, 2001). To ensure maximum participation of all age

groups, all the respondents were further be sub- divided by age (Men 25-35 and 36-45), (women 18-35 and 36-49) to discourage over domination by the much older men and women. Four focused group discussions were conducted, with 2 FGDs being for men and 2 being for women. The FGDs comprised of 8, 10, 11, and 12 members respectively each giving a total of 41 members for the FGDS (18 men and 23 women).

Health providers working in the selected MCH clinics and who agreed to be part of this study were purposefully selected. A total of 4 health workers were sampled for the in-depth interviews. Purposive sampling was used to select 4 community leaders from the 4 select facility catchment areas who were interviewed as key informants.

Table 3.1: Response rate of the study respondents

	In depth Interviews	**Focussed Group discussion**	**Key Informant Interviews**
	3 Men	2 with men (18)	4 community leaders
	3 Women	2 with Women(23)	
	4 Health workers (1 male nurse,1 male clinical officer ,2 female nurses)		
Total	16 respondents	4 (41respondents)	4 Respondents

3.6 Methods of Data Collection and procedures

This section explains the various ways through which data was collected, processed, analyzed and presented. Primary data was collected in this study. In depth Interview guides, key informant guides and focused group discussion guides were used to collect data during the study. Questions were mainly open ended to elicit an in-depth understanding of the phenomenon under study. A letter of transmittal and reference from the University of Nairobi were used to accompany the tools to make the respondents

aware of the research and to cooperate and be assured on confidentiality .The instruments used were:

3.6.1 In-depth interviews

In-depth interviews were conducted within the study population, basically targeting men and women with children under five years and health workers working in MCH clinics in the selected health facilities. 10 men (3 men and 3 women clients) and 4 health workers (2 men and 2 women) were sampled for the in-depth interviews. The interviews collected information about personal views on determinants of male involvement in influencing the utilization of MCH services in the county.

The discussions were guided by semi structured interview guides with open ended questions .The interview guide had a section for demographic information of the respondent (age, location, years in school, marital status and number of children).Some examples of questions included in the interview guide were: What are the roles of men in this community during pregnancy and childbirth? What motivates you/men to accompany your wife to the health facility? What services does your spouse receive in this clinic? What obstacles do your face in accompanying your wife to this clinic? What are the attitudes and opinions of health workers towards you accompanying your spouse in this clinic? The interview guide was in English and the researcher and the research assistant were bilingual. The interviews were conducted in English or Kiswahili, translating simultaneously whenever it was necessary. The interview sessions lasted for 50 to 60 minutes and were all tape recorded. Notes were taken during each interview to supplement the transcripts.

3.6.2 Key Informant Interviews

A total of 4 key informant interviews were conducted with selected male community leaders who have a stake in influencing behavior of fellow men in the county. Two chiefs, one village elder and one religious leader were respondents in this study. The purpose of the key informant interviews was to validate information collected via the in depth interviews and the FGDs and to also give more detailed information about the

phenomena under study (Polit & Beck, 2006). Some of the questions asked during the KII included; in your opinion, why do men accompany their wives/partners to the health facilities during pregnancy and child birth? Comment on the perception of this community on men accompanying their spouses to the MCH clinics, in your opinion, should men accompany their wives/partners to health facilities? The interview sessions lasted for 35 to 60 minutes and were all tape recorded. The research assistant took notes during each interview to supplement the transcripts.

3.6.3 Focus Group Discussions (FGDs)

Focused group discussions were held with married men and women to further validate findings from the individual in depth interviews. A total of 4 FGDs were conducted, two for men and two for women respectively. To ensure maximum participation of all age groups, the FGDs were further sub divided by age to discourage over domination by the much older men and women. The FGDs comprised of 8, 10, 11, and 12 members respectively each giving a total of 41 members for the FGDS (18 men and 23 women)**.** The respondents were not the same as those who participated in the in-depth interviews. Before starting each FGD session, the study was explained to the respondents' individually. After confirming their willingness to participate, the data collections process was started by the moderator and a note taker. Permission was sought from the respondents to tape record the proceedings of the discussions. Selection of the FGD location was based on privacy, quietness and adequate lighting. The moderator then explained the purpose of the FGD, the kind of information needed and how the information would be used .The respondents were encouraged to communicate and interact with each other during the discussion. Each session lasted 50 to 110 minutes. The FGDs were moderated using a FGD guide and proceedings were tape recorded.

3.6.4. Validity of the Instruments

Validity of an instrument is the degree to which it measures what it was truly intended to measure. In qualitative research, this is measured by trustworthiness, dependability and credibility. In this study the instruments used were pilot tested to help check for content and criterion validity. In this study, the instruments were pretested in Mokowe Health centre

immediately after the research assistants training. This helped to estimate the time required to administer the instruments. In addition, this process further helped in identifying ambiguous questions, proper language to use and adjusting the questions or removing them completely. Data triangulation was used in order to increase the rigor of the study whereby different sources of information were used in order to enable an in-depth understanding of the phenomena under study.

3.6.5 Reliability of the Instruments

In research, reliability is the ability of an instrument to yield same results on other occasions even when used by other researchers (Easterby-Smith, 2002). In order to ensure data quality and reliability, research assistants were selected among the Lamu county population where the study was conducted. Both English and Kiswahili languages were used as the situation demanded during the data collection exercise.

3.7 Data Analysis

Summaries for focus group discussions and key-informant interviews were done on a daily basis to prevent any over-laps. It should be noted that all data collection tools were pre-tested before the main survey was undertaken. The pre-test assisted in fine-tuning the data collection tools. It also gave insights in establishing how the main survey was to be rolled-out in terms of methods and resources. Tape recorded interviews were first transcribed verbatim .The transcripts and field notes were read line by line and word by word before content analysis was undertaken.

Content analysis is the systematic qualitative description of the composition of the objectives or materials of the study. It involves 5 key steps ;-Getting to know the data, focusing the analysis, categorizing the information through identification of themes or factors and organizing them into coherent categories, identifying patterns and connections within and between categories and interpreting the results (Polit and Beck, 2006). Data were continuously reviewed and revised, emerging themes and patterns noted and relationships between constructs identified.

3.8 Ethical Considerations

This study like many others could have raised some ethical issues which required redress. Consent of participation was sought from the respondents and confidentiality was ensured as well as informed consent to the respondents to opt out of the study at will at any stage of the study when they felt so. Study respondents were provided with information about the study before any consent to participate was sought Respondents were adequately informed about the;-,Aim of the study and methods to be used, discomfort it may entail, right to abstain from participating in the study, or to withdraw from it at any time without reprisal and measures to ensure confidentiality of information. All the respondents cooperated throughout the time of the study.

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION AND PRESENTATION

4.1 Introduction

This chapter presents analysis and findings of the study that have been discussed under various thematic sections according to the study objectives and questions and the emerging themes during the data analysis as set out in the research methodology. Various themes emerged that were found to be key determinants of male involvement in the utilization of MCH services in Lamu county.

4.2 Demographic Characteristics and response rate of the respondents

Respondents of both sexes and varied age groups above 18 years participated in the study from various areas of Lamu county and drawn from the 4 facility catchment areas of Mpeketoni, Hongwe, Hindi and Kizingitini health facilities. A total of 41 respondents participated in the study out of which 23 were women and 18 were men of different age groups and marital status as shown in *Table 4.1 annexed*. The respondents' age, education level, marital status and occupation among other parameters were also obtained.

4.2.1 In depth Interviews

A total of ten (100 %) in-depth interviews were conducted in this study consisting of five men and five females. Of the male respondents, 3 (60%) were married with children under five years who had accompanied their wives to the health facilities for immunization and growth monitoring whereas 2 (40%) were health workers working in the health facilities. The age group of the male respondents ranged between 26-45, with 4 (90%) of the respondents falling between the ages of 26-36 whereas 1 (10%) were aged between 40-45 years. Among the five female respondents, 3 (60%) were mothers with children under five years of age who had brought them for immunization and growth monitoring, whereas the other 2 (40%) were female nurses working in the health facilities. 2 (40 %) of the female respondents were aged between 25-29 years whereas

the other 3 (60%) were aged between 30-34 years. All the respondents were married with between one and four children.

4.2.2 Focused group discussions

A total of 41 respondents took part in the four FGDs. Among them, 18 were men while 23 were women. Two FGDs were made up of men whereas two were made up of women. 8 (44.4%) among the 18 male respondents were aged between 19 - 35 years whereas the other 10 (55.6%) were aged between 36-55 years. The female FGDs had 11(47.8%) of the respondents aged between 18-34 years whereas 12 (52.2%) of the respondents were aged between 35-49 years. The FGDs were homogenous by residence, marital status and sex but varied by age, parity, education and profession.

4.2.2 Key Informant Interviews

Four (100%) key informant interviews were conducted with all of the respondents being male. Two chiefs, one village elder and one religious leader were respondents in this study. 3 (90%) of the respondents were between 39-58 years whereas one (10%) was aged 35 years.

4.3 Current status of male involvement in MCH services utilization

Findings from the FGDs, in-depth interviews and key informants brought out a number of factors linked to the limited involvement of men in the utilization of MCH services in Lamu county. Some key determinants were identified as age, education level and profession of the men, Culture, religion, gender norms and societal influences, Financial constraints, Lack of time , Polygamy, health service factors, ignorance and lack of awareness and fear of knowing their HIV status.

4.3.1 Socio-Cultural factors as determinants of MCH services utilization

4.3.1.1 Culture, religion and Gender norms

The study revealed that existing gender norms and roles influenced the nature and extends of male involvement in the utilization of MCH services and in the care of their spouses during pregnancy and child birth. Socio-cultural and gender norms and beliefs

emerged as a key factor that discouraged men from being involved in the care of their spouses during pregnancy and after childbirth.

> **''** *My community perceives that pregnancy and delivery is all about women,they would rather their wives are escorted to the clinics (MCH) by their mothers in law, their mothers, or their sisters because this is all about female issues in the facility;they do not think they should be part of women issues''* (Key informant, Kizingitini Health Centre).

A respondent indicated that men accompanying their wives to the clinics was not part of their traditions and roles as men and should never be a point of discussion since this was a new phenomena which was not happening in the olden days and which should not be encouraged at all.

''It is like they have left the customs of our forefathers and followed customs contrarly our forefathers.They are not supposed to accompany women to the delivery room.That is not their place'' (Key informant, Faza Dispemsary).

In addition, most of the respondents concurred that strong cultural beliefs and societal expectations in addition discourage men from being part of their spouses and children's care especially during the first five years of their children's life.

> *'' If my fellow men see me taking my wife to the clinic, or carrying the baby to the clinic, they will start laughing at me, they say ''nimechapwa na chupi '' (I have been henpecked) or (she has bewitched me), or if am seen carrying my baby to the clinic, they will say that'' nimekaliwa'' (that I am voiceless in my home and the woman is in control)*''.(Male FGD respondent, Hindi dispensary).

Some of the respondents further alluded to the fact that religion was a contributor to male non involvement in maternal and child health issues in the community. More so, the Muslim men were far more less involved in the care of their spouses during pregnancy especially accompanying them to the health facility or being part of their care during childbirth.

> ***"****For us Muslims, we do not see it good to accompany our women to the clinic because we believe they are not supposed to have a lot of interactions with women and moreso when they are pregnant or breastfeeding''.It is not right so we leave it to our mothers or their mothers to take care of them''* (Male FGD respondent, Hongwe dispensary).

Respondents noted that some men with more than one wife found it embarrassing to go to the health facility many times with all their wives. Though polygamy was culturally accepted in this community, it acted as a barrier to utilization of MCH services by the men.

> "*Our community is polygamous in nature. Some of the men have more than one wife and it looks funny if they are all pregnant and then he has to take them to the clinic, many prefer not to do it''*.(Key Informant, Hongwe Dispensary).

4.3.2 Socio-Economic factors as determinants of MCH services utilization

4.3.2.1 Financial constraints

The study established that financial constraints on the part of the clients (the men and their spouses) acted as a barrier to utilization of MCH services. These mainly were the user fees for the services and especially during delivery whereby the client is not only required to pay for the service; but also to buy items for use such as gloves, antibiotics, syringes and gauze. This was reported by both the health worker respondents but also the community members during FGDs.

> "*When you read the service charter outside our health centre, it clearly says that services are free for delivery, save for registration which costs 20 shillings, but in real sense that is not true. The client has to buy most of the items needed like gloves, gauze, syringes among others, and they cost money since the government does not supply these things all the time. We tell them to buy because they are crucial during delivery''* (Interview respondent, Kizingitini Health centre).

The respondents lamented that they felt cheated in the facilities since the services which were meant to be free were in actual sense not free; and that was why some were opting to deliver with the traditional birth attendants since their spouses could not afford to pay the user fees in the health facilities.

> "*They say that the services are free for pregnant women, but we found out this is not true and some of us cannot afford them. We have to pay for this and that for example; needles, gauze and laboratory tests at times. Like me, I do not work and my husband cannot afford to feed us and pay the extra money needed at the clinic. He told me he will try to save for the delivery, but he was not able, so a TBA delivered me then I paid her some little money and some sugar to make tea*,'' (Female FGD respondent, Hindi dispensary).

4.3.2.2 Lack of time

Some of the respondents lamented that their working schedules did not permit them to accompany their wives to MCH clinics. Majority of men were busy working mostly in the farms, fishing or working as boat crew and this was a long day job which required them to be absent during such scheduled visits to the clinic.

> "*You see, we are required to put food on the table for our families at the end of the day, and the children must go to school-therefore, I must work the whole day to get this money to feed the family and take the children to school. I do not have time to escort my wife to the clinic every now and then''* (male FGD respondent, Hindi Dispensary).

In addition, some men cited that they work away from home and hence were not available to visit the health facility with their partners / spouses.

4.3.3 Socio-Demographic factors as influencers of MCH services utilization

4.3.3.1 Age and education level

The study established that younger men who had up to form four level of education and above in schooling were more likely to accompany their wives to the health facilities as compared to their much older less schooled counterparts. In addition, the young men were more likely to have spouses who were younger and more schooled as compared to their older counterparts, hence a higher level of involvement in MCH services utilization.

4.3.3.2 Occupation of the men

In addition to age, the study established that men who had white collar/office jobs and farmers were more involved in the health care of their spouses during pregnancy, child birth and the care of their under five children as compared to their counterparts who were casual laborers ,nomadic pastoralists, boat crew or fishermen. This was attributed to the fact that these jobs were stable and hence they could plan their timings better as compared to the other jobs which were casual in nature.

‘’ *It is tricky for some of us men, our types of jobs are quite elusive and demanding. If you cannot report to work so that you take your wife to the clinic, you will be in trouble. You will find someone else has taken over and you are rendered jobless’’*.(Male FGD respondent, Hindi dispensary).

4.3.4 Health Service related factors as influencers of male involvement in MCH services’ utilization

Several health service related factors emerged as some of the barriers to the involvement of men in the utilization of MCH services in the county. Some of the emerging factors linked to the health services included;

4.3.4.1 Humiliation by Health Workers

Some men indicated that they feared being rebuked by health workers in the clinics for lack of proper dressing of their wives. They pointed out that sometimes their women may not have presentable clothes to wear while going to the clinic especially the loose fitting maternity wear which is recommended by the health workers since they (the men) cannot afford them. They further alluded to the fact that health workers sometimes used vulgar language when attending to them which leaves them dissatisfied, opting not to come back again for fear of being humiliated.

> *"My neighbor told me that the last time he came here he was asked why he decided to have another child while he cannot buy his wife good maternity wear; he has since never come back. In fact, his wife never came back again Some say that they cannot escort their wives to the health centers' because they do not have respectable clothes, so they fear to be a shame*" (Male respondent, Hongwe dispensary).

4.3.4.2 Long waiting time

The long queues and long waiting times in the health facilities also scared men from going to health facilities. They lamented that they felt that the MCH clinics did not favour the fact that they needed to work to feed their families and hence could not afford wasting their time just sitting waiting to be attended to.

> "*You see, men want things quick, so it is possible he has gone there and spent a lot of time until noon,so it reaches a point that he loses enthusiasm so the second day he wont return becuse he has other businesses to attend to*" (Indepth Interview respondent, Mpeketoni subdsitric hospital).

4.3.4.3 Poor timing of MCH services

Most of the male respondents alluded to the fact that MCH clinics working hours did not favour their participation. They lamented that these clinics only opened from 9pm to 12 noon and this were peak hours when they were busy at work. With fishing and boat riding being key careers in Lamu, they required them to be at work early when the sea was still calm as compared to the afternoon when the sea is rough and when they do not have much work.

> "*It is unfortunate that these clinics only operate during morning hours on weekdays only when we are busy at work. If only they could open on weekends and late afternoons, then we could be part of the care to our spouses in terms of being with them there. But we do give them money to go there though*" (FGD respondent, Hongwe dispensary).

4.3.4.4 Fear of knowing their HIV status

Some of the respondents reported that most men feared being tested for Sexually transmitted diseases and HIV during the ANC visits with some further adding that some men thought that HIV testing and counseling was the only reason they were required to accompany their spouses to the health facility and that other aspects such as health education and childbirth preparedness's were not meant for them. Some of the respondents further indicated that they feared being seen going to the facility by their peers as these could imply that they are HIV positive.

> "*You see, they want us to accompany our wives to the clinic for ANC and testing for HIV; and this is not a welcome idea for most of us, we fear being found positive, if our wives get tested and they are negative, then we are relieved, but if not, we are in trouble''*(Male FGD respondent, Hindi Dispensary).

This was further supported by the women who alluded to the fact that if there was no testing for HIV in the MCH clinics, maybe more men would be attending.

> "*It really is all about the testing for HIV. We are encouraged to bring our husbands along, but when we tell them, they get annoyed ,they become harsh towards us and they tell us that they are not going for any test, they are just not*

willing, they are afraid of the outcomes'' (Female FGD respondent, Hongwe Dispensary).

4.3.4.5 Lack of awareness

Lack of awareness of the benefits of escorting their wives to health facilities was cited as a reason why most men do not accompany their wives to the MCH clinics. They thought that it was just an obligation of their wives to go there and not them. Majority reported not knowing why women have to keep on going there yet they were not sick. For the children's' immunization, majority of the men thought that it was because the governments' requirement that they take their children to the clinics hence they reason they supported their wives with money to do so.

"*My wife keeps on telling me that she must go to the clinic, yet she is not sick, I do not understand why she has to do it. There were no clinics in the olden days, but women used to give birth without problems, what is new now that they must go?*'' (Male FGD respondent, Mpeketoni sub district hospital).

Some of the respondents confirmed that some of them (women) were afraid of their husbands and did not talk to them regarding escorting them to the health facility.

4.3.6 Community Perceptions as determinants of MCH services utilization

4.3.6.1. Community attitudes

Some women respondents reported that men generally fear going near a maternity area, or being seen walking with their pregnant wives on the streets by their peers for fear or being mocked whenever they go for social gatherings or when they are in the company of fellow men.

''My husband once took me to the health clinic when I was nine months pregnant because my feet where swollen. You see, we had to pass through the market because that is the way. you should have heard his peers laughing loudly and asking him why he was going to the women's zone', he was disturbed for some weeks and he has since ever escorted me again'' (Female FGD respondent, Mpeketoni sub-district hospital)

Some of the respondents reported that the community was polygamous and sometimes old men have married young wives and hence may find it difficult to escort those who are much younger to the health facility for fear of being seen with them'

> "*The age difference blocks some men from escorting their wives to the health centers' because you will find when these men are very old; they find it difficult to be seen responsible for the pregnancy of younger girls*.'' (Key informant, Kizingitini Health centre).

4.4 Reported benefits of Male Involvement in the MCH Services

Although not a main objective, the study sought to find out some of the perceived benefits of male involvement in MCH services utilization. The few men who accompanied their spouses to the health facilities during pregnancy, child birth and scheduled days for their children under five years pointed out a number of benefits that they received during such visits. key among them were learning the benefits of ANC, they were taught together with their spouses on the need for the preparation of individual birth plans, in the preparation for their children's' birth, identification of some danger signs in pregnancy such as bleeding and signs of hypertension, anaemia, nutrition for their spouses during pregnancy and their children and their role in providing for the right nutritional foods. This also helped to allay the harmful myths associated with eating some foods such as eggs and some types of fish during pregnancy which are not held by proven facts. They in addition were much more informed in making decision regarding the choice of where their spouses will deliver since they now knew the advantages of hospital delivery as opposed to home delivery.

> ***"****Going to the health facility with my wife really taught me a lot of things which even if she had spent a whole day explaining to me , I would not understand since she is not a medic'' The nurse really spend a lot of time teaching us the importance of preparing for the birth of our child, how to recognize danger signs which are fatal is left unattended, saving a little within the pregnancy period for*

the delivery and incase of any complications among many lessons. Surely, I have become so informed about pregnancy, child birth and child rearing. All men should become part''. (Male Interview respondent, Hindi dispensary)**.**

The respondents further alluded that accompanying their spouses really made them aware of their own health and their contribution to the well being of their family. It also helped to improve their bond as a couple and their communication since they now spoke the same language health wise. The respondents further pointed out important health aspects both for them, their spouses and their family in general. Such include knowing their HIV status and family planning and birth spacing of their children.

"*I now know my HIV status and that of my spouse, we have chosen a family planning method that my wife is currently suing and our child is growing well now. We have come for birth monitoring of our child and we are really happy that we chose to do this since my wife was five months pregnant, it has made us better parents and we are very grateful to the health workers here*.''(Male Interview respondent, Kizingitini Health Centre).

4.5 Suggested approaches for male involvement in utilization of MCH services in Lamu county

The study further established that some of the strategies that may be used to involve men more in the utilization of the MCH services. A number of approaches were suggested that could see an increase in the number of men/ couples utilizing MCH services in the county. These included; community awareness and engagement forums, introduction of health days for men in the clinics and use of male champions in the community**.**

4.5.1 Community Awareness and Engagement forums

A majority of the study respondents were of the opinion that men needed to have a change in behavior through adoption of new ways of doing things as opposed to holding on to the traditional cultural and gender norms which only led to deterioration of the

health care of their families. For this to happen there was need for intensive awareness creation and sensitization to achieve maximum results. Behavior change communication strategies through use of media and Information, Education and communication materials were critical ways suggested by majority of the respondents in addition to use of churches, mosques, chief's Barazas and male only and/or couple seminars to reach a bigger audience. The respondents noted that sporting events and cultural festivals such as the annual Lamu festival would be an ideal medium through which to engage men and teach them on the importance of their participation in the health of the spouses, their children and their family in general.

> "*They need to be woken up, they need to be made aware that there are many benefits to being involved as husbands and there are many ways of doing it. There is Bahari FM (a local radio station) and others; there is television, posters, campaigns, barazas and even our Lamu event every year" We can reach all of them with information through these channels*.''(Interview respondent, Kizingitini Health centre).

Respondents, both male and female concurred that most men were not aware of their roles and that societal gender roles had blinded them to opening up to MCH issues. Culture and religion were accused of being players and hence solvers of the current dilemma.

> "*It is not their wish to be the way they are currently, our society has made it that way. But if we educate them, if we empower them (men) with the right knowledge and understanding, they will embrace it and be part. They are our husbands, they are not bad. It is lack of knowledge and guidance''* (Female FGD respondent, Mpeketoni sub district hospital)**.**

4.5.2 Introduction of health days for men and male friendly clinics in the Health Facilities

This was suggested as a medium through which men could be reached and educated in issues pertaining to their health and MCH as well. Respondents felt that may be the issue

of MCH was labeled as a female affair and as such this could be the reason many men were not participating. They suggested that the government needed to introduce health days targeting men that could see more men reached and get involved. In addition, male friendly clinics would ensure that men were treated with the privacy and promptness that they required given their limited time in the clinics. For these to happen, respondents felt that health workers needed to be retrained on how to handle men in the health facilities since their attitudes towards them was wanting.

> "*You notice that the facilities are labeled ;maternal and child health, not family or men, this could be the reason they(men) do not take it seriously and will not come since this is not their place. If only the government could initiate health days targeting men in the MCH clinics and teach them their roles, then may be things could change''* (Female FGD respondent, Hindi dispensary).

4.5.3 Advocacy through use of male champions in the county

Respondents felt that peers played a big role in influencing the participation of men in the utilization of the MCH services. They suggested that male champions, mainly influencers of behavior in the county could be a way of calling on men to take on their roles and be involved in the utilization of the MCH services in the county. Such champions would include Chiefs, Religious leaders, the governor, teachers among other respected people in the county. These people would play a key role in influencing the behavior of fellow men if they acted as models and took part in the utilization of MCH services in the county.

> "*There are many men who emulate the community leaders here like the governor, the Madrasa teachers, chiefs etc in the way they do their things. If we want to reach them, we need to go through these people to talk to them or just be role models. This way, we will change the behavior of many''* (indepth Interview respondent, Mpeketoni sub district hospital).

CHAPTER FIVE

SUMMARY OF THE FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter provides summary of the findings from chapter four, conclusions and recommendations based on the objectives of the study. The overall objective of this study was to establish the determinants of male involvement in the utilization of maternal and child health services in Lamu county of Coastal Kenya. The study was guided by five key objectives whose findings are summarized in the section below. The study employed a qualitative descriptive design and the results were analyzed through use of descriptive statistics mainly content analysis.

5.2 Summary of the Findings

The study sought to gain an understanding of the determinants of male involvement in the utilization of maternal and child health services in Lamu county of Coastal Kenya. Respondents were drawn from the health facilities and the health facility catchment area in the target county. The background characteristics of the respondents were obtained prior to gathering information from them. Such included the age, sex , profession, marital status and their level of education. Majority of those who participated in the study were married with children at least one of their children less than five years. The study established that socio-cultural factors including culture, religion and gender norms, socio-demographic factors, economic factors, community perceptions as well as health services related factors all play a compounding role in pushing away men from getting involved in the utilization of MCH services in Lamu county. The study further highlights key benefits of involving men in the utilization of MCH services which include; knowing their HIV status and that of their spouses, learning about danger signs to watch for during pregnancy, letting to learn about FP and taking part in planning for their family, getting to understand issues about nutrition for the family, the spouse and their children as well as getting to plan for individualized birth plan for the spouses including emergency

preparedness in case of complications of pregnancy and delivery. The study further gives recommendations of some of the strategies that can be adopted at various levels; at individual level, at the community level, at the health facility level as well as at policy level to ensure maximum involvement of men in the utilization of MCH services in the county.

5.3 Discussion

This section focuses on a detailed discussion of the major findings of the study which also entails comparing the study findings to previous literature in the same field. The study established a number of factors that influence the involvement of men in the utilization of MCH services in Lamu county. Several factors were explored in chapter four and findings discussed herein. The study revealed that the proportion of males who participated in the utilization of MCH services in Lamu county was relatively low. These findings are related to previous findings by other researchers from the country, the region and across the globe. A study done in Western Kenya in 2010 that sought to establish the facilitators and barriers to male involvement in sexual and reproductive health established that male participation was poor and this was linked to various factors among them culture and overriding traditions in the region (Onyango et al., 2010).

The findings in this study indicate that the prevailing social cultural and religious norms in Lamu county determine the gender roles and responsibilities as well as societal expectations of men and women which hinder men from participating in MCH services utilization. The findings of this study are consistent with findings of other studies carried out in various parts of Africa. In their study carried out in Eastern Uganda,(Byamugisha et al., 2010) and his colleagues found out that culture, tradition, community perceptions and gender norms were key barriers to the involvement of men in PMTCT services. The study exposes some of the deep rooted cultural and traditionally propagated behaviors of men that have serious implications on the maternal and child health care and which may be contributing to the high maternal and child morbidities and mortalities in Lamu county. These traditionally and culturally sanctioned practices such as polygamy, male and female gender roles and beliefs regarding male participation in MCH care have

created an environment where most of the men, key decision makers in their families are not expected to be actively involved in maternal and child health care of their spouses and children in the first place. A majority of these men are not aware and hence do not get involved in this important aspect of parenting and family reproductive health matters.

The study further established that financial constraints on men were impacting negatively on male involvement in MCH services within the county, given that majority of them had not acquired any form of formal training. User fees at health facilities coupled with constant stock outs of key supplies in the MCH clinics required that the men purchase those items and this further helped to push them farther away from participating in the utilization of MCH services. This finding is similar to other findings by previous researchers in the same field that established that economic strengths of the man in a family played a key role in determining the utilization of reproductive health services of their spouse and their involvement. A study carried out in Northern Tanzania found out that the earning power of the male spouse and his education level and a direct relationship to the seeking of MCH care especially ANC and PMTCT services and this is linked to deliveries at the health facility (Kowalscky et al., 2012).

The findings of this study bring out key issues revolving around the health facility, the health providers and the health services themselves. The study reveals some of the barriers to male involvement in the MCH services utilization to be the poor timing of the MCH services and the long waiting time at the health facilities. These findings are related to findings of (Ditekemena et al.,2011) and by (Byamugisha et al.,2010) who found out that male participation in ANC and PMTCT services was poor and this was largely because MCH services where these services are offered are only done on weekdays and in the morning when they (men) are busy at work .In addition, the health provider attitudes and reaction towards men who accompany their spouses to the MCH services was a key contributor to their non participation in the MCH services uptake. The study reveals that men get humiliated by health workers especially when they cannot raise the required user fees and this makes them uncomfortable when getting involved in the utilization of MCH services. These findings are pointed by (Byamugisha et al., 2010) in a

study carried out in Uganda that established that the harsh language used by the health workers was a barrier to male participation in PMTCT services. This observation has further been alluded to by (Mulany,2010) who point out at the big role that care givers play in promoting or dissuading male participation in the utilization of MCH services.

The study findings further concur with findings by (Onyango et al.,2010) that found out that most men fear knowing their HIV status and thus proffered sending their spouses to the health facilities accompanied by their female counterparts; either the sisters, their aunties or their mother in laws.

The study goes further to highlight the poor community perceptions and attitudes towards men who participate in the care of their spouses. Men who get involved in the MCH services utilization were often regarded as weak in their families, a barrier highlighted by (Mulany,2010) who allude that community perception and opinions regarding men who were involved in MCH services utilization beyond the household had contributed to the low male involvement in MCH. In the study, Bhatta and Dharma (2013) assert that some men are embarrassed to be seen in ANC clinics which have for a long time being perceived as female places with some men fearing that they would be perceived as dominated by their wives.

This study revealed lack of knowledge and awareness on issues regarding male involvement and participation in MCH services as a crucial factor as to why few men where participating in the utilization of these services. This can be attributed to the low uptake of skilled birth attendance at birth by most pregnant women who attend the first ANC visit in the county hence the high maternal and newborn mortality in the county. These findings are consistent with findings from a study done in Nepal that found out that mes' lack of knowledge regarding the importance of MCH services to pregnant women and children under five years played a key role in determining their involvement (Mullany, 2010).

5.4 Conclusions

The study explored various determining factors to the involvement of men in the utilization of MCH services in Lamu county. The study concludes that several factors among them the socio-cultural, demographic, economic and health services related factors play a key role in influencing male involvement in the utilization of maternal and child health services in the county. Socio-cultural and economic factors seem to play a key role in influencing the involvement of men and their participation in the care of their spouses during pregnancy and child birth. Socio-cultural factors such as traditions, religion, polygamy and gender roles seem to be leading influencers of male involvement in MCH services utilization. Economic factors such as user fees have been pointed out in this study as contributing to the underutilization of MCH services by men in Lamu county.

The study further alludes that the demographic characteristics such as the age of men, their marital status and their level of education have a relationship to the level of male involvement in the utilization of MCH services. In addition, the study reveals that a variety of factors revolving around the health services themselves play a key role in determining the utilization of MCH services by men.

Finally, the study concludes that for men to be fully involved in the utilization of MCH services in Lamu county, all the determining factors highlighted above should be addressed at different levels and by all the stakeholders involved. Some of the strategies suggested in the study include; the need to create awareness among men regarding their roles in the MCH care and the need to adopt behavior change strategies in MCH programming by government and partners to address the cultural linked factors that seem to play a pivotal role in dissuading men from being involved in the care of their spouses and children in MCH. The study further concludes that the health system will require to be strengthened to be more inviting to men who are involved among them the need to scrap user fees, the need to exercise flexibility in timing of the MCH services to later in the afternoons or weekends to attract men seeking to use these services and the

reorientation of health workers to be able to embrace men as users of the service and not just onlookers.

5.5. Recommendations

Based on the findings and conclusion of the study, a number of recommendations have been made to the government and policy, partners in MCH services delivery in the county and researchers in the field of MCH:

5.5.1 Recommendations to government and policy makers

1. Literature review from previous studies and findings from this study have established that male involvement in MCH is still weak despite the 1994 ICPD conference resolution that male involvement is very key to the success of such programmes. There is therefore a need for the government and policy makers in general in the field of MCH to mainstream male involvement in MCH services and move away from the traditional approaches of MCH which placed the man at the periphery of reproductive health programmes. This should be supported with stronger policies in place which will be implemented at all levels of health care for them to succeed.

2. Health providers should be re-oriented on the importance of male involvement in MCH.These re-orientation trainings should seek to integrate the role of men in MCH services utilization and the need to be male friendly if greater gains in MCH are to be achieved. These trainings should focus on approaches to encourage more male participation at all levels of care and in the whole continuum of MCH care.

3. Government led strategies of sensitizing and educating men on their roles and responsibilities in MCH should be drawn and implemented in Lamu county. These strategies should be supported, monitored and evaluated from time to time to ensure that they succeed.

4. The issue of user fees which is a barrier to male involvement in MCH services utilization should be addressed. Though MCH services are free in the lower levels

of care, this policy does not seem to function since the facilities are lacking in key supplies forcing them to become costly for the residents of Lamu. The county government should address this and ensure a continuous supply of MCH commodities and avoid stock outs

5. To increase male involvement in maternal health care services in the county, the county health managers have to ensure the availability of essential MCH supplies at the health facilities and ensure flexibility of the MCH opening and closing timings.

5.5.2 Recommendations to MCH stakeholders

1. There is need for stakeholders in MCH in the county; non-governmental organizations, civil society groups, community based organization and other institutions to redesign MCH programmes to address male involvement as a key entry point to achieving results given their key role in decision making in the family and their economic role in providing for finances.

2. MCH stakeholders in the county should work to create awareness on the importance and benefits of male involvement in maternal health care service utilization. This could be achieved through the development and implementation of behavior change strategies that specifically target men in the county. These could be rolled out through planned county wide awareness campaigns through available channels such as the mass media and community leaders with the aim of addressing traditional norms and gender defined roles which act as barriers to male involvement in MCH programmes.

5.5.3 Recommendations for further research

This study has established the key determinants of male involvement in the utilization of MCH services .The study recommends that further research be undertaken to investigate the relationship between sexual reproductive health education on the boy child and their

future utilization of MCH services. Other studies include the role of men in taking up family planning in the same county**.**

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APPENDICES

Appendix I: Letter of intent

Nguku Angela Ndunge,

P.O.Box 1079-00200,

NAIROBI

June 6th 2013

Dear Sir/Madam,

My name is Angela Nguku,a student at the University of Nairobi pursuing a Master of Arts degree in Project Planning and Management. I am writing to invite you to participate in a research inform of a face to face interview. My research focuses on the determinants of male involvement in the utilization of maternal and child health services in your county. The interview is should take between 30-60 minutes and the findings will be submitted to the University of Nairobi in partial fulfillment of the degree of Master of Arts in Project Planning and Management.

I wish to assure you that the information that you provide will be treated as confidential and it will be kept in the faculty at the University of Nairobi. Access to the information will be provided in this interview will be restricted to the supervisor and to myself

We hope that you will participate in this survey since your views are highly valued. The information you provide is confidential and will be used solely for this purpose. You may choose to opt out at any time of the study.

I look forward to your assistance.

Yours sincerely,

Angela Nguku

Appendix II: Data Collection Tools

1. In- depth Interview Guide (Men/women)

Determinants of male involvement in the utilization of maternal and child health services in Lamu county?

Respondent No……

Sex…….

Marital Status……

Education level……..

No. of Children……

Occupation……

Location……

1. For men

1. What are the roles of men in this community during pregnancy and childbirth?
2. What motivates you to accompany your wife to the health facility?
3. What services does your spouse receive in this clinic?
4. What obstacles do your face in accompanying your wife to this clinic?
5. What are your barriers to accompanying your wife to the health facility?
6. What are the attitudes and opinions of health workers towards you accompanying your spouse in this clinic?
7. Would you accompany your wife next time she is visiting the clinic? If NO,why

2. For women

1. What are the roles of men in this community during pregnancy and childbirth?

2. What motivates your spouse to accompany you to the MCH clinic?
3. What obstacles does he face when accompanying your wife to this MCH clinic?
4. What are the barriers that he faces when accompanying you to the facility?
5. Are there any barriers that deter him from accompanying you to the MCH clinic?
6. What are the perceptions of health workers towards you accompanying your spouse in this clinic?
7. Would you accompany your wife next time she is visiting the MCH clinic

2. Focus Group Discussion Guide (Women / Men)

Determinants of male involvement in the utilization of maternal and child health services in Lamu county?

INSTRUCTIONS TO THE RECORDER

i. Please write down the respondent numbers, marital status, education levels,occupation,age and number of children for all the respondents of the FGD on your note book

ii. Please write down the discussion points/ responses on a note book and use the tape recorder to record their responses

GENERAL

Name of the Moderator……

Name of note taker…….

Number of respondents……..

Date of the FGD: ……..

Start time…… End time…….

Location……

1st Scenario

We are going to talk about Amina and Abdi now. Abdi is 35 years old and living with his wife. Abdis' wife is 3 months pregnant. Yesterday, he agreed to company his wife to the clinic. Amina was very proud to have her husband accompany her to the ANC. On the way to the clinic, they met friends and relatives who admired them. After arriving at the clinic, the midwife praised Abdi. The midwife shared the examination results with Abdi and the wife and participated in devising an Individual Birth Plan including a choice of where the couple wished to deliver the baby.

1. What good things did Abdi do, if any?
2. What bad things did Abdi do, if any?
3. Please explain/mention factors which hinder men from accompanying their wives to the MCH clinic.
4. Explain the importance of men in the care of their pregnant spouses
5. In you opinion, what is the perception of health providers towards men who accompany their wives to the MCH clinics.
6. Explain factors which motivate men to accompany their wives to the MCH clinics.
7. Mention some of the factors which discourage men in attending MCH clinics? Probe for attitudes and opinions of health workers
8. Do you have anything else you would like to add? Are there any recommendations you would like to make regarding this topic?

2nd Scenario

We are going talk about Nasra and Abubakar now. Abubakar is 40 years old; He is living with his wife who is pregnant for the third time. She has no child. Her first born died at birth due to complications related to obstructed labour. She did not visit the MCH clinic since she did not have the means and the mother in law and the husband wanted her to deliver at home. The second child died 3 days after delivery due to birth asphyxia-the husband refused to take her to the hospital for fear of being laughed at by fellow men in the village and being scorned by his mother-who would look at this as being a feminine role. The last time Nasra attended the MCH clinic after the death of her last baby, she was advised on a few things such as that her spouse needed to do in monitoring the pregnancy and preparing for the birth of the baby. She spoke to her husband who refused, citing the reasons above.

1. What do you think about Abubakars' reactions during all the 3 pregnancies? Probe for opinions regarding male partner involvement during pregnancy and child birth

2. Please explain/mention those factors that may hinder men from accompanying their wives to clinic. Probe for (economic,demographic,cultural,social factors)
3. In terms of benefits to the family, do you think men accompanying their wives/partners are a worthy cause? Probe for opinions from different respondents
4. What do you think are the challenges that men face when getting involved in the care of pregnancy and childbirth in this community
5. What is your take on men getting involved during pregnancy and childbirth? Do you think it is of benefit or no benefit to the family? What's your recommendation regarding male involvement?
6. Do you have anything else you would like to say or add?

3. Key Informant Interview Guide

Determinants of male involvement in the utilization of maternal and child health services in Lamu county?

Respondent No:…….

Sex…….

Marital Status……

Education level……..

No. of Children……

Occupation…….

Location……..

1. Are you aware of the services provided to women during pregnancy and child birth in the facilities within these communities?

   -If so, please mention them.

2. Are you aware of men who accompany their wives/ partners to the heath facilities during pregnancy and childbirth in this community?

   -If so please give examples / cases that you know.

3. In your opinion, why do men accompany their wives/partners to the health facilities during pregnancy and child growth monitoring
4. Comment on the perception of this community on men accompanying their spouses to the MCH clinics. - Probe for social, cultural, religious and economic factors.
5. According to your opinion, should men accompany their wives/partners to the MCH clinics? Please explain

6. Comment on the perceptions of (health workers and community) in general towards men who accompany their spouses to the MCH clinics.
7. What do you think are the challenges that men face when getting involved in the care of their spouses during pregnancy and child birth
8. As a community leader, what is your take on men getting involved during pregnancy and childbirth? What's your recommendation/suggestions regarding male involvement?

Appendix III: Demographic characteristics of the respondents

	In depth interviews(n=10)	Focus Group Discussion(n=41)	Key Informant interviews(n=4)
Age group(yrs)			
18-30	5	13	0
31-40	4	16	2
41-50	1	12	1
51-60	0	0	1
Sex			
Female	5		
Male	5		
Location			
Kizingitini	3	8	1
Faza	2	11	1
Hindi	2	10	1
Mpeketoni	3	12	1
Years in School			
Never been to school	0	3	0
Primary level	2	17	1
Secondary	4	16	1
Tertiary	4	5	2
Marital Status			
Single	0	5	0
Married	10	27	4
Separated	0	9	0
Divorced	0	0	0
# of Children			
1—2	4	15	1
3—5	6	21	2
6-above	0	5	1
Occupation			
Housewife	3	13	0
Farmer	2	9	0
Fisherman	0	4	0
Teacher	1	0	0
Nurse	3	0	0
Clinical Officer	1	0	0

Casual labourer	0	3	0
Boat crew	0	2	0
Porter	0	3	0
Pastoralist	0	4	0
Village Elder	0	0	1
Chief	0	0	2
Religious leader	0	0	1
Businessmen/ women	0	3	1