

THE INFLUENCE OF MALE SPOUSE PARTICIPATION IN MATERNAL UTILISATION OF ANTENATAL CARE IN NJORO TOWN, NAKURU COUNTY, KENYA

^{1*} **Barnabas Frank Rotich**
barnabas.rotich@egerton.ac.ke

^{2**} **Ruth A. Aura-Odhiambo**
runyangi@yahoo.com

^{3***} **Stellamaris Muthoka**
skaveni@yahoo.com

¹ Institute of Women, Gender and Development Studies, Egerton University. P.O. BOX 536-20115, Egerton

² Faculty of Law, Egerton University. P.O. BOX 536-20115, Egerton

³ Department of Human Nutrition, Egerton University. P.O. BOX 536-20115, Egerton, Kenya

Abstract: *In patriarchal communities such as those in most African settings, men take central position in decision making, control household resources and control their reproductive behaviours and that of their sexual partners. They hold critical role in preparations for birth and actions needed in case of an emergency during the process. Despite their benefits in maternal utilization of antenatal care, few men participate in these services. The study aim was to investigate the influence of male spouse participation in maternal utilization of antenatal care in Njoro town, Nakuru County. The study was carried out in the two health centres in Njoro town. It employed descriptive survey design. Sample size of 279 participants was obtained using convenient sampling procedure. Structured interviews, focus group discussions and key informant interviews were used in data collection. The data was analyzed qualitatively and quantitatively. Findings of the study were presented using quotes, narratives, pie-charts, bar graphs and frequency tables. From the study finding, 79% of the male spouses gave financial support to their partners while 28% made decision on which health facility their spouses would visit for delivery. Further, the study found out that, 43% of male spouse took part in maternal nutrition during pre and post-partum while 28% of male spouse took part in other related maternal support. Factors like income levels, age, level of education and number of children among other influenced men's participation in maternal related services. This study recommends that health providers should involve male spouse in maternal health.*

Keywords: *Influence, Male spouse, participation, Maternal Utilisation, antenatal care*

Background Information

Globally, the involvement of men in maternal health programs has been related with positive reproductive health outcomes, such as increase in the uptake of interventions to prevent HIV transmission, use of contraceptives and improved maternal health outcomes (Yargawa & Leonardi-Bee, 2015). In most patriarchal society, men are major decision makers and they hold primary power over household resources and decision making. This make them to have profound power over preparations for birth and the actions needed in case of an emergency (Maternal & Neonatal Health Program, 2004). According to Kwambai et al., (2013) men's decision making power and control over household resources affect maternal health including the choice of health services.

A number of international instruments such as Convention on the Elimination of All Forms of Discrimination against Women and the African Charter (CEDAW) and African Charter on Human and Peoples Rights (ACHPR) have acknowledged the critical role of men in increasing access to and utilisation of maternal health services. For instance in Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1995), recognises that the unequal status of women in society hampers their equal access to adequate health care. Accordingly, the article obligates state parties to ensure that women have access to health care on equal basis with men. State parties are required to remove all legal and social barriers that obstruct access to health care for women. According to the African Charter on Human and Peoples Rights (ACHPR, 2014), particularly Article 14, the state parties are obligated to provide adequate, affordable and accessible health care services. Male spouse participation and support will facilitate the protection of female spouses as per the article in utilising antenatal care after delivery (Odimegwu et al., 2005).

Despite these benefits, few men participate in maternal health services their involvement has been slow, and the lack of progress is a likely contributor to the sub-optimal advancement towards the achievement of the United Nations SDGs 3 and 5. Which seeks to ensure health, promote well-being for all at all ages and to achieve gender equality (UN, 2015). The decision making power of women to utilise health services during pregnancy, childbirth, post-partum, newborn care and family planning is limited with decisions being taken by relatives and husbands, which may lead to delays in seeking professional care.

Social responsibilities, such as the need for women to provide for the families and care for the young children, sometimes stand in the way of using or utilising the antenatal care services by limiting the time the mothers have for attending antenatal care and other health care services (Onyango, Owok & Ogutu, 2010). To increase male spouse participation in mothers' utilisation of antenatal care services and maternal health care services requires that the providers gain in-depth knowledge and understanding of the men's health perspectives, behaviour and practices (Kaye et al., 2014)

Pregnancy is not an illness; though it creates a great deal of physical and emotional demands on the mother. The husbands, as well as other family members need to understand and appreciate the discomfort and tiredness that pregnancy may cause in the woman (Hall et al., 2009). The awareness about the demands of pregnancy on the part of the husband and other family members could result in the necessary support the pregnant woman needs from the family members including the husband (Onyango, Owok & Ogutu, 2010). In the contemporary society, male spouses tend to overcome the patriarchal culture that frowns upon their participation in the maternal utilisation of antenatal care. Factors which discourage male spouses from being in the labour ward affect gender mainstreaming in the achievement of Sustainable Development Goals (SDG) on ensuring healthy lives and promoting the wellbeing for all at all ages United Nation General Assembly report (UNGA, 2015).

The presence of a male companion in antenatal care is a rare occurrence in many African communities. This trend is prescribed by tradition and it is, therefore, deeply entrenched. As an aspect of male spouse behaviour the trend has important implications for the use of antenatal care by women and it has negative consequences for the health of mothers and children (Schetter & Tanner, 2012). In Njoro town, Nakuru County, antenatal care is not fully utilised by the mothers. One reason for this undesirable state of affairs may be sought in the inadequacy of male spouse participation in the said utilisation. The government, through the Ministry of Health, has made efforts to intervene in this deficient situation so as to stimulate male spouse participation in the antenatal care. However, the level of such participation and the results of the interventions made towards improving it have so far been outlined only in general terms (Schetter & Tanner, 2012).

Fathers' involvement is associated with the quality of couple's relationship and satisfaction towards parental function knowledge and primacy of work (Condon, 2006; Glenn & Quilin, 2007). In addition, they should take individual responsibility as husbands and fathers to become involved in changing social attitudes including taking responsibility for reproductive health issues. However, their involvement has been slow, and this may have contributed to the sub-optimal advancement towards the achievement of Sustainable Development Goals (SDGs) 3 and 5 United Nations (UN, 2015).

A number of studies in Africa have explored male involvement in maternal health programs. In Kenya, although men were aware of the benefits of their involvement in maternal health, negative health worker attitudes, perception of pregnancy support as a female role and unfriendly antenatal care services limited male involvement (Kululanga, Sundby & Chirwa, 2011). According to Bawah (2002) most efforts on male involvement on health issues have been centred on sexual and reproductive health issues such as condom use, family planning decision making and prevention of mother to child transmission (PMTCT) of HIV.

Efforts have been made by the governments through the Ministry of Health in Kenya to encourage male spouse participation in the mothers' utilization of antenatal care as well as infant and young child nutrition (Kwambai et al., 2013). However, there are limited studies that has been carried out to determine the level of their influence on infant and young child feeding. This, therefore, informed the need to carry out a study to find out the influence of male spouse participation on infant feeding to improve the mothers' utilization of antenatal care after child birth.

Male spouse participation will facilitate the protection of female spouses as per the report on utilizing antenatal care (ANC) and promoting the wellbeing for all at all ages (UNGA Report, 2015). Male spouse participation in the mothers' utilisation of antenatal care is in line with the Kenya Government policies which seek to improve overall livelihoods by providing an efficient and high quality health care system. Infant and maternal mortality rates can be lowered by reducing inequalities in the health sector key areas Government of Kenya (GOK, 2013).

In Kenya, most cultures discourage men from participating in matters concerning infant and young child feeding. However, the young generation is moving away from that old culture because of debates in the social media concerning male spouse participation in the mothers' utilization of antenatal care.

Methodology

The study employed descriptive survey design. Sample size of 279 participants was obtained using convenient sampling procedure. Structured interviews, focus group discussions and key informant interviews were used in data collection. The instruments were pilot tested in Molo sub-county to determine reliability which was found to be 0.819 which is above the threshold of 0.7 this is an indication that the instruments were reliable. The data was analysed qualitatively and quantitatively. Findings of the study were presented using quotes, narratives, pie-charts, bar graphs and frequency tables.

Results and Discussions

Socio-demographic characteristics of female respondents

Socio-demographic characteristics for female respondents is as shown in Table 1.

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

Table 1. Demographic Characteristics of the female respondents (n = 279)

Indicator	Frequency(n)	Percentage
Age		
17-24years	164	58.8
25 years and above	115	41.2
Education level		
Primary	70	25.1
Secondary	128	45.9
Tertiary	47	16.8
University	33	11.8
No formal education	9	3.2
Occupation		
House wife	130	46.6
Employed	103	36.9
Business	46	16.5
Religion		
Christian	273	97.8
Muslim	6	2.2
Marital status		
Married	253	90.7
Single	14	5.0
Widowed	4	1.4
Separated	6	2.2
Divorced	2	0.7
Prior knowledge of ANC service		
Yes	225	80.6
No	54	19.4
Distance to health facility		
Less than 5km	176	63.1
5km and more	103	36.9
Source of information on ANC		
Health care workers	136	48.7
Books and media	64	22.9
Relatives, friends & church	79	28.4
Mean number of children born to the mother	3	SD=(1.769)
Mean number of pregnancy to the mother	2	SD=(1.171)
Mean number of living children	3	SD=(1.803)

Source: field data

The results in table 1 show the background information of the mothers utilising antenatal care which indicated that 58.8 percent aged between 17-25 years and 41.2 percent aged 25 years and above. The study showed that 45.9 percent and 25.1 percent of the female spouses had secondary and primary education levels respectively. The results indicate that 46.6 percent of the females were housewives, 36.9 percent and 16.5 percent of the

female spouses were employed and had businesses. The study showed that 90.7 percent of the female spouses were married, with 5.0 percent and 2.2 percent single and separated respectively.

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

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

Level of Male Spouse Participation in Mothers’ Utilization of Antenatal Care Services

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

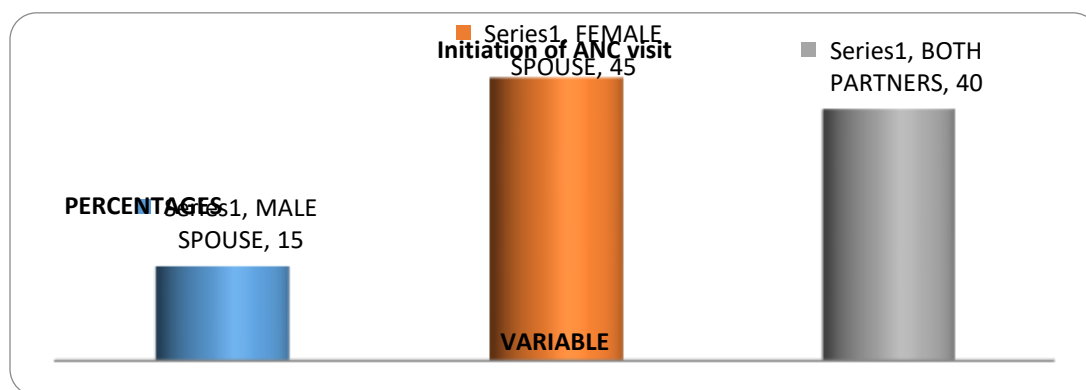


Figure 1 initiation of ANC visit among study population

From figure 1, Male spouses who initiated the antenatal care visit were 15 percent compared to 45 percent female spouses who initiated the same. Antenatal care initiated visits by both spouses stood at forty (40) percent.

Decision Making on Selection of Health Facility for Antenatal Care

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

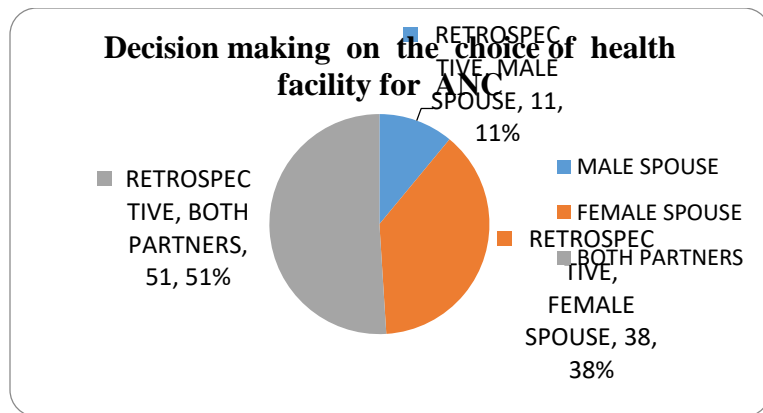


Figure 2. Decision making levels on the choice of health facility to visit for antenatal care

Figure 2 shows that 11 percent of male spouses made decision on the choice of the health facility to visit for antenatal care while joint decision making was 51 percent and 38 percent of the mothers made decision on the choice of health facility to visit for antenatal care.

Financial Support

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

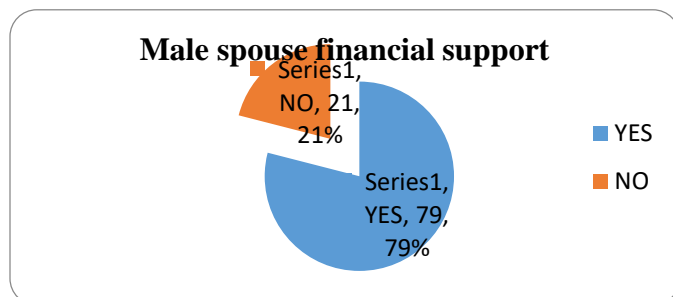


Figure 3 Male spouse financial support to their spouses attending ANC

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

Selection of Health Facility for Delivery

Selection of the health facility for delivery by the male, female and both spouses/partners is shown in figure 4 Male spouse participation in the selection of the health facility for delivery was 28 percent while the selection by female spouse alone was 26 percent.

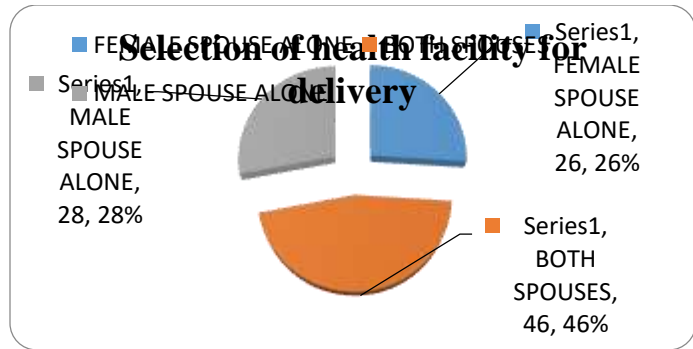


Figure 4: Decision making levels on the health facility to visit during delivery

Accompanying of Spouse to Health Facility during Delivery

The success or gains made in the mothers’ utilisation of antenatal care was determined by the percentage of male spouses who accompanied their female spouses for antenatal care visits. Figure 5 shows the proportion of male spouses who accompanied their spouses to the health facility during delivery.

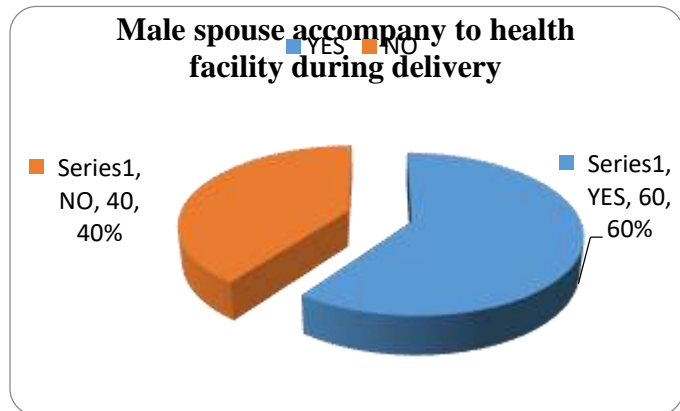


Figure 5 Male spouses who accompanied their female spouse to health

Figure 5 indicated that 60 percent male spouses accompanied their spouses to the health facility for delivery to ensure they reached hospital safely but could not enter into the delivery room compared to 40 percent who did not.

Male Spouse Influence on Mothers’ Utilisation of Antenatal Care

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

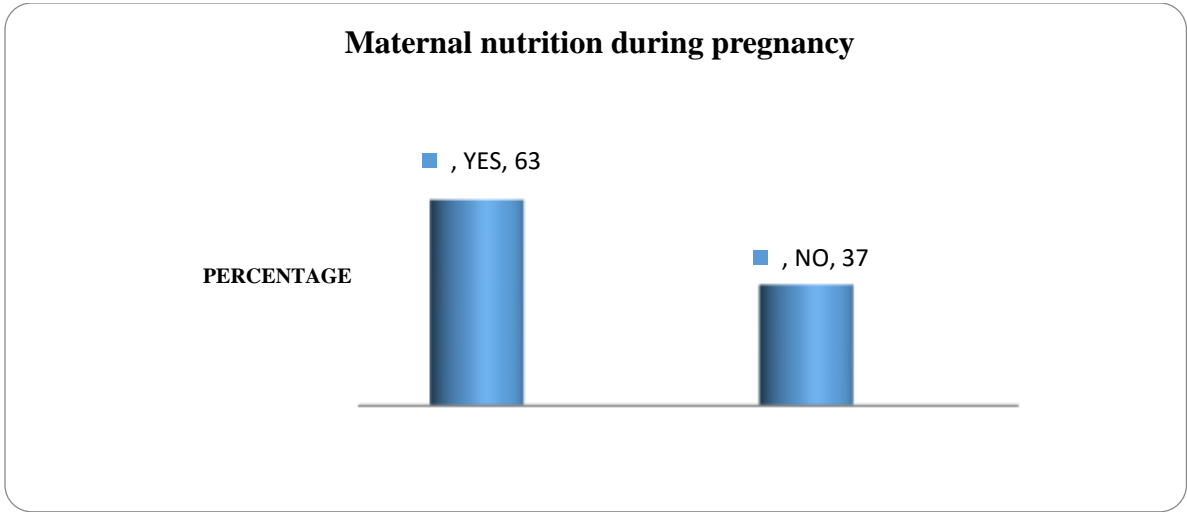


Figure 6 Male spouse contributions to maternal nutrition during pregnancy

From figure 6, Male spouses who were reported to support the mothers in terms of maternal nutrition during the pregnancy were 63 percent as compared to 37 percent of male spouses who did not give any support for maternal nutrition during prenatal and postpartum.

Table 2 Level of male spouse participation in utilisation of antenatal care

LEVEL OF MALE SPOUSE PARTICIPATION	PERCENTAGE (%) Target	Recorded Achievement	Raw score	RANKING
Initiation of ANC visit	100	15	4.7000	Poor
Choice of health facility for ANC	100	11	4.7800	Poor
Financial support	100	79	3.4200	Very good
Choice of health facility for delivery	100	28	4.4400	Poor
Accompaniment to health facility for delivery	100	60	3.8000	Good
Male spouse nutritional support during pre- and post-partum	100	63	3.7400	Good
Total	600	256	24.8800	Fair/low

Source: Field Data 2010

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

The discussion gives discourse of other related results from previous related studies.

Level of Male Spouse Participation in Maternal Utilization of Antenatal Care

The level of male spouse participation was determined by their frequency of participation in influencing decision on the timing of antenatal care visits, financial support for antenatal care visits, and decision on the health care facility for delivery.

“My spouse does not participate or accompany me because of lack of money and time and he would prefer going out to look for money for upkeep than waste his time with clinic issues. He is difficult to convince or persuade.” (Respondent 1, Huruma, FGD)

”Most of the challenges I face in supporting my wife has to do with finances for fare, lab tests and profiling.”
(Respondent 2, PCEA, Njoro)

“Mothers are discouraged by the harassment they undergo at the clinic from the lady nurses. We prefer being attended by male nurses and this seem not going down well with our spouses. A nurse would answer you “do not touch me, am not your husband”.” **(Respondent 2, Huruma, FGD)**

“I was not able to support my wife because she became very moody and emotional and could quarrel with me every time I entered the house.” Making it difficult even for women to accept gestures of their husbands to accompany them to the health care facility. **(Respondent 3, CMA, St. Lwanga, Njoro)**

“The mother fears being touched or receiving injection from young health care workers and even in the morning i heard from the radio **(Respondent 4, Hyrum, FGD)**

Another factor that was mentioned as inhibiting male spouse participation in the antenatal care was the long queues at the government health centres hence the need for the expansion of the facilities and hiring of more health care workers to meet the demand for utilisation of antenatal services. According to the nursing officer at the Njoro Health Centre:

“The reception at the health facility is unfriendly and hostile sometimes hence discouraging men from participating in maternal utilisation of antenatal care.” **(Respondent 2, CMA, St. Lwanga, Njoro)**

The implication is that the latter group (ages 55-60) were stable financially and attached great importance to the antenatal care while the mid age group had other financial obligations like school fees, medical bills rents and other expenses thus giving little for maternal support. The fact that antenatal and maternity were free contributed also to reduced support from the male spouse.

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

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

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

“Male spouse do not discuss or accompany their wives to the health unit for ANC, delivery or postnatal care services because they think it is not a big issue, but they would do so if the health of the mother is at risk due to complications.” (K1, PCEA Hospital, Njoro)

Male Spouse Influence on Mothers’ Utilization of Antenatal Care

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

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

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

Challenges associated with Male Spouse Participation in Mothers’ Utilisation of ANC

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

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

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

Health care policy does not allow men and un- authorized person's entry into the delivery room in Kenyan public hospitals and health centres and this may be part of the reason why some men are not showing keenness in accompanying their partners for maternal health care. Men in the FGD expressed little willingness to participate in the whole process of delivery and at best ensured that their spouses reached hospital in good time and were in the care of the health care workers. In private health centres like PCEA Njoro, there is practically no restriction for male spouses who are willing to accompany their spouses to the delivery room. Similar findings were reported in the study carried out in Natal, South Africa, where few men indicated that even when they accompanied their partners to the clinic, they generally waited outside for the outcome (Mullick Busi & Wanjiru, 2009). Since most public hospitals are heavily occupied they may not be able to accommodate male spouses into labour wards. Staff shortage in health facilities may also not be conducive to allowing male spouse in case of need. These findings imply that much as there is advocacy for increased shared gender roles and male spouse participation in maternal health, a great deal needs to be done in terms of infrastructure and logistics to enable male spouse participation in the utilisation of antenatal care.

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

In the male FGD younger and older men highlighted reluctance on the part of their spouses to share healthcare and antenatal care visit reports, which contributed to low male spouse participation in the mothers' utilisation of antenatal care. Some men reported that their spouses did not brief them on any antenatal care visit while some men got reports on the progress on the growth of the foetus, the weight of the mother and other physical or blood tests carried out. The mothers report from the antenatal care visits enhanced the knowledge of their male spouses thus making them part of the process with the mothers affirming the cultural practices and belief that the man's role is to provide transport and check on the child health care card.

These findings are consistent with several other studies that have reported that even when men encourage their partners to seek care and get involved there is still lack of information on postnatal care (Kululanga, Sundby & Chirwa, 2011). In Nepal, women who shared information with their husbands were more likely to experience heightened male spouse participation (Arora et al, 2000). Similar findings reported in a study carried out in Nepal in 2003 suggest that the level of male awareness of the services offered during antenatal and postnatal

care in Njoro town is still low. Lack of discussion between the spouses after the antenatal care visit contributed to the low level of awareness by the male spouse.

Conclusion

Although a high proportion of males' spouses in Njoro town were aware of the antenatal care, most of them did not accompany their spouses during the antenatal care visits despite being instrumental in making decision on selecting antenatal care facilities. With respect to the health facility choice for delivery, a good number of male spouses discussed with their spouses. Financial support, though a challenge, was one of the supports that steadily came from the male spouses with the provision of fare being the outstanding one.

Level of male spouse participation in utilisation of antenatal care and their influence in maternal young child nutrition in Njoro town was low in both the retrospective and prospective surveys and therefore more effort is required to encourage male spouse participation in the utilisation of antenatal care and maternal health care services. Factors that were found to affect the level of male spouse participation in the mothers' utilisation of antenatal care were lack of finances, free time from work, socio-cultural issues as well as masculinity, patriarchy, and poor attitude of health care worker to client. Male spouse participated keenly in the utilisation of antenatal care when there was a complication or high risk on the pregnancy.

Recommendations for further study

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

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

Competing interests

The author(s) declare that they have no competing interests.

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Ethical approval

Ethical approval was obtained from the Ethics and Research Committee of Egerton University. Verbal informed consent for participation and discussions was obtained from each participant. Information obtained was used for the purposes of the study. The researcher practiced veracity, non-maleficance and beneficence by being honest, straightforward, causing no harm or embarrassment and by doing good to the participants.

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