MALE PARTNER INVOLVEMENT IN CHOICE OF DELIVERY SITE AMONG WOMEN DELIVERING AT COAST LEVEL FIVE HOSPITAL MOMBASA COUNTY, KENYA

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APRIL, 2015
DECLARATION

This thesis is my original work and has not been presented for a degree in any other university

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To my late parents Onchong’a and Nyasuguta. My wife Peace and my brother Nemwel for their support and encouragement.
ACKNOWLEDGEMENT

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Finally, I would like to extend my appreciation to all members of staff of Coast Level Five Hospital and the KMTC Mombasa Campus nursing students who were my research assistants for their splendid work during data collection.
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DEFINITION OF TERMS

Age: Is the number of complete years one has lived since birth.

Barrier: Any factor, belief, practice that may hinder or block someone from performing an expected activity or behaviour.

Delivery site: Is the actual place of giving birth, whether at home or health facility

Determinant: Refers to factor(s) that predict occurrence of a given behaviour or practice.

Income: Is the amount of money earned through salary and any other source per month.

Knowledge: Refers to the respondents understanding of the meaning and benefits of male partner involvement in choice of delivery site.

Male partner involvement: Refers to male partner participation in discussing and agreeing on the delivery site and the male partner providing support to the woman to access the chosen site.

Male partner: Is any adult man who is married or is in an informal union with a woman and takes care and supports her.

“Mwenyewe”: A Swahili term used to refer to the male partner responsible of the pregnancy.

Marginal effects: This is a statistical operation used to determine the effect of a change in an independent variable(s) on the dependent variable(s).
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Clinic</td>
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<tr>
<td>ATR</td>
<td>African traditional religion</td>
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<tr>
<td>DRH</td>
<td>Division of Reproductive Health</td>
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<tr>
<td>ERC</td>
<td>Ethical and review committee</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>GOK</td>
<td>Government of Kenya</td>
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<td>IDI</td>
<td>In-depth Interview</td>
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<tr>
<td>JHPIEGO</td>
<td>John Hopkins Program for International Education in Gynaecology and Obstetrics</td>
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<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
</tr>
<tr>
<td>KMTC</td>
<td>Kenya Medical Training College</td>
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<tr>
<td>KSHS</td>
<td>Kenya shillings</td>
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<td>Kenyatta University</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MOPHS</td>
<td>Ministry of Public Health and Sanitation</td>
</tr>
<tr>
<td>NACOSTI</td>
<td>National Commission for Science, Technology and innovation</td>
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<tr>
<td>PGH</td>
<td>Provincial Government Hospital</td>
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<tr>
<td>PNW</td>
<td>Postnatal Ward</td>
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<tr>
<td>RA</td>
<td>Research Assistant</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

Maternal mortality is one of the major worldwide health challenges. The high maternal mortality rate is a common subject in global health and development discussions. Globally, about 800 women die daily from pregnancy or childbirth-related complications. Men’s involvement during pregnancy and childbirth plays a vital role in the safety of their female partners during pregnancy and childbirth by ensuring access to care and provision of emotional and financial support and guarantying the women’s access to reproductive health services in general. This study aimed to establish male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital, Mombasa County. This was a descriptive cross-sectional study that targeted women who delivered at Coast Level Five Hospital and their male partners. Systematic sampling was used to select the participants. A semi-structured questionnaire and focus group discussion guide were used to collect data. These tools were pre-tested at Port Reitz District Hospital. The quantitative data were analysed using descriptive and inferential statistics. Statistical analysis was performed using chi-square, logistic regression and marginal effects. The analysed quantitative data were presented in text, graphs and tables. The qualitative data were analysed and categorised into sub-themes and themes and presented as direct quotes and narrations. The study findings revealed that there is low male partner involvement (40.6%). Women and male partners’ education (p<0.001), women income (p=0.006) and male partners’ income (p=0.024), women knowledge (p<0.001), women perception (p=0.001) and male partners’ perception (p=0.001) had significant influence on male partner involvement. Influence of cultural and reproductive health policy awareness could not be ascertained as their frequencies were too few. To improve male partner involvement, there is need for the Mombasa County Government and management of Coast Level Five Hospital to come up with strategies/programs to promote male involvement, promote education and facilitate economic empowerment, create awareness on importance of male involvement in RH through media and community barazas and disseminate the national RH policy. In addition formulate policies that will ensure male partners get time off from their place of work to accompany their spouses to ANC.
CHAPTER ONE: INTRODUCTION

1.1 Background of the problem

The unacceptably high maternal mortality rate has become a common subject in global health and development conferences. Many women die every day from pregnancy or childbirth–related complications and in 2010, 287,000 women died during and following pregnancy and childbirth. Almost all (99%) of these deaths occurred in developing countries (WHO, 2010). In Kenya, a major challenge towards attainment of millennium development goal (MDG) number five which targets to reduce maternal mortality by ¾ between 1990 and 2015 and vision 2030 is the high maternal mortality ratio of 488/100,000 (KDHS, 2009). Despite the fact more than 90% of women received antenatal care from medical personnel, only 44% got skilled attendant delivery (KDHS, 2009).

Men’s involvement during pregnancy and childbirth plays a vital role in the safety of their female partners’ pregnancy and childbirth by ensuring access to care and provision of emotional and financial support (Iliyasu et al., 2010) and guarantying women’s access to reproductive health services in general (Speizer et al., 2005).

Iliyasu et al., (2010) in their study argued that men have social and economic power and have tremendous control over their partners. They decide the timing and conditions of sexual relations, family size and whether their spouse will utilize available health care services. Prenatal male involvement has been associated with positive outcomes for the mother and baby, which include more antenatal care visits, cessation of smoking and alcohol consumption, participation in high-risk behaviour reduction strategies to prevent vertical HIV transmission and more birth preparedness in case of pregnancy complications (Babalola et al., 2009 & Iliyasu et al., 2010).
Hence this situation makes male partner involvement critical for improvement in maternal health and reduction of maternal morbidity and mortality (JHPIEGO, 2001).

According to John Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO, 2001), in Sub-Saharan Africa pregnancy and childbirth continue to be viewed as solely a woman’s issue. Accordingly, finding a male companion at antenatal clinic is rare and in many communities, it is unthinkable to find male companions accompanying a woman to the labour room during delivery Babalola et al. (2009).

Though the role of men in maternity care is under-studied in Africa, open discussion between partners on where to give birth improves skilled delivery service uptake at health facilities (Mpembeni et al., 2007). Peer-led, culturally sensitive community education increases males’ involvement and improves service uptake (Magoma et al., 2010). Some pregnant women attending Coast Level Five Hospital report waiting for the male partner to discuss and make the decision on delivery site; though some do this when labour has started. However, little is known on how many practice this as there are no records kept at the facility.

Studies conducted in different countries indicate that social, cultural, and religious factors play a paramount role in skilled birth attendance (SBA) service uptake (Baral et al., 2010 & Iliyasu et al., 2010). In addition, Nanjala et al. (2012) reported that cultural beliefs among male partners influenced male partner involvement in RH activities. At Coast Level Five Hospital, not much is known on the influence of these factors; in addition to knowledge, perception and awareness of reproductive health policy on male partner involvement in choice of delivery site.
1.2 Statement of the problem

At Coast Level Five Hospital, most of the women who develop complications during pregnancy and childbirth report to the facility late. The main reason given for reporting late is that these women wait for the male partner (mwenye) to give consent before seeking skilled delivery and to make transport arrangement. This leads to delays in decision making and accessing the health services putting the life of the women and the unborn babies at risk.

In addition, few male partners accompany their spouse to ANC where among other things a birth plan that includes choice of delivery site is discussed. Furthermore, even the few who accompany their spouse are not documented. Therefore it is difficult to establish the proportion of male partners who are involved in making a birth plan and those who are not.

Despite health education at ANC, through mass media and sensitization at community level during outreaches to empower both women and men with knowledge on male involvement in reproductive health programs and promote positive attitude, there is no data showing their knowledge and perception level and the influence of knowledge and perception on male partner involvement. Although the Kenya National Reproductive Health Policy that promotes male involvement in reproductive health has been in place since 2007, little is known on the women and male partners’ awareness of this policy and the influence of this awareness on male partner involvement in choice of delivery site. The purpose of this study was to establish the level of male partner involvement, influence of women and male partners’ socio-demographic and economic factors, knowledge and perception, cultural beliefs and awareness of reproductive health policy on choice of delivery site among women delivering at Coast Level Five Hospital, Mombasa County.
1.3 Justification of the study

Studies have highlighted the important role played by men in making decisions pertaining to maternal health issues and have called for male-involvement in MCHN (Carter et al., 2005). The Kenya National Reproductive Health Strategy 2009-2015 identifies male involvement in maternal health is one of the foundations on which the six pillars of maternal health stand (GOK, 2009). Additionally, male partners are key decision-makers including seeking health services, are culturally house heads, and financial providers for the family. Women access to and utilization of emergency obstetric services, skilled birth attendance and MCNH all depend on male partner involvement.

Agreement of partners regarding the importance of delivery in the health facility is associated with a higher likelihood of women delivering in a health facility (Danforth et al., 2009). Male involvement enables men to support their spouses to utilize emergency obstetric services early and the couple would adequately prepare for birth and ready themselves for complications. This can lead to a reduction in all three phases of delay (that is delay in making decision to seek care, delay in accessing the care and delay in receiving the care) (Odimegwu et al., 2005). Male partner involvement is key in reducing the number of women dying due to pregnancy and child-birth related complications and achieving millennium development goal number 4 and 5 by 2015.

Previous studies have concentrated on male partner involvement in family planning and PMTCT and few on male partner involvement in choice of delivery site. Currently, no similar study has been conducted in Mombasa County to establish male partner involvement in choice of delivery site.
1.4 Research questions

1. What is the level of male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital?

2. Which socio-demographic and economic factors influence male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital?

3. What is the influence of knowledge and perceptions on male partner involvement in choice of delivery site at Coast Level Five Hospital?

4. What is the influence of cultural beliefs and awareness of reproductive health policy on male partner involvement in choice delivery site among women delivering at Coast Level Five Hospital?

1.5 Objectives of the study

1.5.1 Broad objectives

To establish male partner involvement in the choice of delivery site among women delivering at Coast Level Five Hospital, Mombasa County.

1.5.2 Specific objective

1. To establish the level of male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital.

2. To determine the socio-demographic and economic factors influencing male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital.

3. To explore the influence of knowledge and perception on male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital.
4. To establish the influence of cultural beliefs and awareness of reproductive health policy on male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital.

1.6 Significance of the study

Findings from this study may inform the health facility management to come up with initiatives that promote male involvement and eventually better utilization of skilled birth attendance. This will contribute to reduction of the unacceptably high maternal mortality ratio associated with home delivery. The findings will also contribute to the existing body of knowledge on male partner involvement in choice of delivery site.
CHAPTER TWO: LITERATURE REVIEW

2.1 pregnancy outcomes

Globally, women die every day from pregnancy or childbirth-related complications; mostly (99%) occurring in developing countries (WHO, 2010). In developing countries, 1 woman in 16 may die from pregnancy-related complications as compared to 1 in 2800 in developed countries. Most of these deaths can be averted even where resources are limited (WHO, 2004).

Most maternal deaths occur during labour, delivery and the immediate postpartum period. Obstetric haemorrhage is the main direct cause accounting for 25% of maternal deaths, infections (15%), unsafe abortion (13%), eclampsia (12%) and obstructed labour (8%) (Ronsmans et al., 2006). The high maternal mortality ratio in Kenya pose a significant challenge towards attainment of Millennium Development Goal (MDG) number five by 2015 and vision 2030 if not well addressed (KDHS, 2009).

2.2 Male Involvement in reproductive health

2.2.1 Global perspective of male involvement in reproductive health

All over the world there is an increasing interest in mainstreaming male participation in reproductive health, since men usually are the key decision-makers in the home and often control household finances. In reducing maternal mortality, the value of direct male involvement in maternal health care cannot be underestimated. Reducing maternal deaths by 75% throughout the world by 2015 will take the involvement of men in countries where it matters most (USAID, 2010).

Despite global recognition at the level of international agreements, many countries have not developed large-scale programs that reach out to men. As a result, many men are not aware of why they need to be involved in sexual and reproductive health
(SRH), how they can be involved, and what services are available for them and their partners. Involving men is particularly challenging in countries whose culturally defined gender roles may hinder men’s participation (Waltson, 2005). Involving men in SRH in such settings is complicated and demands a long-term commitment. The potential benefits of men’s involvement include expanded rights for women, improved family health, better communication between partners, and joint and informed decision-making within households (Waltson, 2005).

In Cambodia, male involvement in RH is still underdeveloped. Compared with women, Cambodia has developed only a few indicators for male involvement (Waltson, 2005). Traditional gender differences in Cambodian society tend to impede the benefits of male involvement in reproductive health. Reproductive health is usually considered a woman’s concern both within households and at the policy level, where strategies and legislation rarely specify male involvement as a core component of RH interventions (Waltson, 2005).

In rural Bangladesh, family dynamics present a barrier to delivery care. Many individuals in a woman’s social network play a role in decisions about reproductive health care utilization, especially when acute problems arise (Rahman et al., 2011). Decisions about professional delivery are made at a crisis point, when a woman’s home labour is perceived to be progressing poorly. Close family members in the household, including mothers-in-law and other female in-laws, often give opinions on how to proceed (Pankhurst et al., 2006).
Still in Bangladesh, men often make decisions about women's health care because women are structurally and culturally dependent on men due to their limited mobility and limited educational and economic opportunities (Paul et al., 2002). This means that even though men may be discouraged from being involved in matters of pregnancy and childbirth, as is the case in the region, their beliefs and perceptions might influence where and how their wives give birth (Story et al., 2012). The study further suggests that a husband’s social support and social norms are associated with his wife’s use of delivery care.

2.2.2 Regional perspective of male involvement in reproductive health

In some parts of Nigeria, spousal permission is important before a woman in emergency obstetric conditions attend to health care. In the absence of the ‘chief’ (husband) of the household, any male must accompany the woman to the clinic; but it seems that women wait for the husband (Raimi et al., 1999). In Senegal, women do not decide on their own to seek health care; the decision belongs to the spouse or senior family members. It is accepted that delaying the decision to seek care could be a factor of maternal complications or death (Dia, 2005). A study done in Burkina Faso revealed that the traditional necessity for women to have the permission of husband or their relatives before leaving the home predominates (Some et al., 2013).

In Tanzania, strategic decisions regarding delivery in a health facility are likely influenced by partners and other household members (Allendorf, 2007)). Another study in Western Tanzania indicated that couples with a recent delivery; agreement of
partners regarding the importance of delivery in the health facility was associated with a higher likelihood of women delivering in a health facility (Danforth et al., 2009).

Although some studies have suggested that male partners act as obstacles when it comes to safe delivery care (Adeleye et al., 2007), male involvement during pregnancy and childbirth can lead to positive birth outcomes for the mother and child as well as a healthier marital relationship (Carter, 2002). Including men more consistently and meaningfully in decision-making about the use of essential reproductive healthcare has the potential to contribute to reducing maternal and neonatal mortality (Greene et al., 2000).

2.2.3 Local perspective of male partner involvement in reproductive health

Few studies have examined male involvement in reproductive health in Kenya (Onyango et al., 2010). Figures are not available on the number of male partners that accompany their wives, either for ANC or delivery care, but based on anecdotal evidence these are low in the Kenyan setting (Kwambai et al., 2013).

A qualitative study conducted in Kakamega (Western Province) revealed among other findings that men did not want their partners to use contraceptives for fear of extramarital sex. The same study showed that couples rarely discuss issues such as STIs and HIV for fear of accusation of marital infidelity (Fapohunda et al., 1999). In another study conducted at Nairobi’s Kenyatta hospital and Kakamega provincial hospital in western Kenya concluded that men do participate in women centred reproductive health services to some extent. The majority of men accompany their wives to the hospital if there are fees to be paid, for obstetric/gynaecological (ob/gyn) consultations, delivery, and antenatal care (Muia et al., 2000).
In contrast to the above study, a study conducted with samples drawn from Nyanza, Western and Rift Valley provinces by Onyango et al. (2010), most participants, both male and female, from all the three provinces and across all cultures and age groups, were of the opinion that men in Western Kenya were not sufficiently involved in reproductive health. Involving them, participants cautioned, would be a challenging undertaking. This study revealed that the existing gender norms among cultures in Western Kenya influence and determine the extent of male involvement in reproductive health. Four factors were mentioned by participants to illustrate how men exhibit these norms: negative cultural practices, parenting practices in relation to reproductive health, prevention and treatment of sexually transmitted infections (STIs), and accompanying/not accompanying female partners to the health facilities.

Men in Western Kenya rarely accompany their partners to the RH clinics, a fact attributed to gender norms, low awareness, and lack of male reproductive health education programs. As a result, many men do not think it is important to participate in reproductive health issues. The opinion of peers also has an impact on male involvement. A man who usually accompanies the wife to the clinic is branded as being overpowered by her. Thus, for most men, involvement in maternal and child health and reproductive health issues implies a weakness—they won’t be seen as total men (Onyango et al., 2010). The same study reported that the respondents argued that the way reproductive health services are traditionally implemented by the health care systems contributes not only to a lack of male involvement in reproductive health but also to most men’s limited knowledge of reproductive health issues.
2.3 Level of male involvement in choice of delivery site

Involving husbands and encouraging joint decision-making in reproductive and family health may provide an important strategy in achieving maternal health goals (Mullany, 2005). A study in Ethiopia by Wassie et al., (2014) established high (90.4%) male involvement in deciding the place of delivery regardless of the place of delivery. Dia (2005) showed in his study in Senegal that 52% of the decisions on delivery site were made by the husbands while 44% were made by another member of the family.

In a study in Uganda about half (56%) of male partners were involved in deciding spouses’ place of delivery (Kabakyenga et al., 2014). Other studies done in Uganda revealed that joint couple decision-making is low for choice of delivery site at 32.5% for Jinja district (Nantamu, 2011), while one conducted in Kooki county Rakai district, reported a 71.3% joint decision-making on choice of delivery site (Bua, 2008).

In Nyandarua Kenya, Wanjira et al., (2011) established that 58.4% of the women interviewed had their place of delivery decided by their husbands. A quantitative study in Asembo Kenya reported that majority of the women (87%) made these decisions on delivery site on their own (Van et al., 2006). In addition, data from the Kenyan Demographic and Health Survey 2008/2009 (KDHS, 2009) showed that 73% of women reported that they either made their own decision, or a joint decision with regard to health care. Despite the available literature review, the level of male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital remains unknown. As such, the current study established the level of male partner involvement in choice of delivery among women delivering at Coast Level Five Hospital.
2.4 The Socio-demographic and economic factors influencing male partner involvement in choice of delivery site

Social and demographic factors such as wealth and education are important in the power relationships between partners and more directly in determining use of health services (Yanagisawa et al., 2006).

2.4.1 Influence of women and male partners’ age and male partner involvement in choice of delivery site

The literature reviewed show that age of the women and male partners to significantly influence male partner involvement. However, in Ethiopia one study showed no statistical significant difference in the median age of males who were involved in decision making and those who were not (Wassie et al., 2014). In contrast to the survey findings, male FGD participants mentioned that young males were more involved in selecting health facility as a place of delivery than those who are elderly and less educated (Wassie et al., (2014).

A study in Kinshasa Zaire by Ditekemena et al., (2012) found that male involvement was 1.2 times higher among men whose female partners were 25 years or older. Similarly a study in Western Kenya showed that majority of participants mentioned that most married men (especially the older generation) rarely discuss reproductive health issues with their wives and children while the younger generation is considered more open and can talk more freely about reproductive health (Onyango et al., 2010).

A study in Busia Kenya, established no statistical difference between the age of a male partner and type of delivery of spouse (skilled or unskilled). It further revealed that the
number of women who were attended to by skilled birth attendants was seen to decrease with increasing age so that young women aged 35 years and below were more likely to seek services from skilled attendants than women aged 36 years and above (Nanjala et al., 2012).

2.4.2 Influence of women and male partners’ income on male partner involvement in choice of delivery site

In one study in Ethiopia it was shown that the odds for male involvement in decisions on delivery site in couples with a joint source of family income coming from both partners is four times greater than those with an income from only one of them. The researcher further argue that this may be due to the fact that additional sources of income gave male partners the power to be able to cover related costs. It may also be due to male partners’ attitude towards economically supportive spouses, making them accountable and more responsible (Wassie et al., 2014).

A cross-sectional study done in Southern Tanzania by Mpembeni et al., (2007) established that women of high economic status sought skilled care at birth because they were able to make wise decisions about their health and meet the costs of the same. In Kenya, Reece et al., (2010) reported that men in occasional and low-paid jobs were less likely to accompany their spouses to the health services than their counterparts.
2.4.3 Influence of women and male partners’ education on male partner involvement in choice of delivery site

The influence of education level on male partner involvement in choice of delivery site varies from one country to another and among studies. A study in India established that education of men was the most important factor governing the involvement of men into their wives health (Narang et al., 2013).

Results from a study of Salvadoran fathers’ by Carter et al., (2005) showed that attendance at prenatal care, delivery and postpartum care where men with more than a primary school education were more likely than their less educated counterparts to participate in birth related activities. This study further established that educated mothers were more likely to seek skilled care due to increased knowledge of the benefits of preventive health care and awareness of health services, higher receptivity to new health-related information, more control over resources within the household and better communication with the husband, more decision-making power among others reasons.

Iliyasu et al., (2010) in a study in Northern Nigeria to assess birth preparedness, and fathers’ participation in maternity care, established that husbands with formal education were more likely to participate in maternity care compared to those with non-formal education. In a Ghanaian study conducted by Esena et al., (2013) it was noted that educated women had better pregnancy outcomes than uneducated ones, as they usually selected health facilities for delivery service in consultation with their partners.
Studies conducted in Ethiopia showed contrasting results. In one study no relationship between male involvement and male partners’ or their spouses’ level of education. Paradoxically, the male and female FGDs in this same study showed that the level of male partner education influenced male partner involvement in deciding in favour of delivering at health facilities (Wassie et al., 2014). Other studies in Ethiopia showed that more men with post secondary education were involved in decisions on delivery site compared to those without formal education (64% and 39% respectively) (Paavilanen, 2013). Furthermore, Amano, et al. (2012) also concluded that husband’s educational levels are connected to the decision about delivery place, higher levels being contributing to institutional deliver.

A study in Kinshasa Zaire revealed that the level of education of pregnant women or their male partner did not influence male participation (Ditekemena et al., 2012). This however contrasts a study in Uganda by Byamugisha et al., (2010) that found that men who had completed 8 or more years of education were twice more often involved compared with those with less than 8 years of education. As argued by Nanjala et al., (2012). Education also enables men to discard the negative attitudes and cultural beliefs.

Despite the literature reviewed, the influence of socio-demographic and economic factors on male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital remains unknown. This study established the influence of socio-demographic and economic factors on male partner involvement in choice of delivery among women delivering at Coast Level Five Hospital
2.5 Influence of the respondents’ knowledge and perception on male partner involvement in choice of delivery site

2.5.1 Influence of knowledge on male partner involvement in choice of delivery site

Mullany et al., (2006) in a randomised controlled trial conducted in urban Nepal established that educating mothers and spouses to understand the complications of pregnancy and child birth led to an increased uptake of maternal and child health services. In Nepal, low knowledge levels appeared to pose a significant obstacle to males becoming actively involved. In general, both male and female respondents’ knowledge surrounding pregnancy was limited particularly in relation to complications or danger signs during pregnancy, labour or delivery (Mullany, 2006). Although men in Nepal are typically discouraged from involvement in pregnancy and childbirth issues, some husbands were interested in supporting pregnancy health; but their lack of knowledge about maternal health posed a significant obstacle to becoming positively involved (Mullany, 2006).

In a study in Tanzania, poor understanding among men of the health problems faced by mothers and babies, lack of knowledge regarding how to take an active role in maternal and child health have been identified as barriers to male involvement in some settings (Theuring et al., 2009).

A study done in Busia Kenya reported that low knowledge regarding complications associated with pregnancy and delivery has been identified as determinant for male partner involvement in promoting skilled birth attendant (Nanjala et al., 2012).
2.5.2 Influence of the respondents’ Perceptions on male partner involvement in choice of delivery site

Several studies have reported negative perceptions towards men attending ANC services. In one report, men who accompanied their wives to ANC services were perceived as being dominated by their wives. Frequently men perceive that ANC services are designed and reserved for women, thus are embarrassed to find themselves in such “female” places (Byamugisha et al., 2010).

A study in Nepal revealed that several Nepali phrases or idioms have been coined for husbands who are viewed as ‘too’ supportive or involved with their wives. Joitingre (“hen-pecked”), swasniko mutna bageko, or a man being “swept away by the urine of the wife” was used to describe a man who takes orders from a wife. In joint families, members ridicule and tease a male when he is trying to get involved and he might become discouraged by this (Mully, 2006).

Nkouh et al., (2010) in their study in Cameroon showed that fear of being perceived as a jealous husband following his wife around was one of the reasons for lack of involvement ANC services. In a study in Malawi, it was found that women considered childbirth as a preserve for women and not an area for men to be involved (Kululanga et al., 2012).

Men in western Kenya rarely accompany their partners to the RH clinics, a fact attributed to gender norms, low awareness, and lack of male reproductive health education programs. As a result, many men do not think it is important to participate in
reproductive health issues with excuses such as being busy or that reproductive health is a woman’s responsibility (Onyango et al., 2010).

A qualitative study conducted at Asembo Nyanza, most participants across the FGDs echoed issues preventing them from being involved in either ANC or delivery care. Firstly, this was seen as a ‘female’ role and thus the responsibility of mother-in-laws or co-wives rather than the male. Secondly, as head of household and provider, men’s focus was on economic activity which was more important for them to concentrate on at this time (Kwambai et al., 2013).

In the other study done at Asembo Kenya, it was established that opinion of peers had an impact on male involvement. A man accompanied the wife to the clinic was branded as being overpowered by her. Remarks from peers such as, “This one drops the wife to the clinic” or “He goes to the women’s clinic” were viewed as insulting and kept the men away from reproductive health clinics. Men loathe being branded as amekaliwa (Kiswahili for being henpecked) by their female partners (Onyango et al., 2010).

According to Nanjala et al., (2012) in a study at Busia Kenya, majority of men regarded delivery as a natural phenomenon and hence saw no need of being involved. They further argue that the thinking of men that delivery is a natural phenomenon could be due to lack of knowledge regarding the complications that are associated with pregnancy, labour and delivery, and this perception has affected the male partner involvement in supporting their spouses in accessing delivery services from skilled attendants. Some men reported that they would be regarded by relatives and fellow male colleagues as being “ruled” by their wives if they were seen taking part in child birth issues.
Even after reviewing the available literature, the influence of knowledge of male involvement and its benefits and perception towards male involvement in choice of delivery among women delivering at Coast Level Five Hospital is still unknown. As such this study established the influence of knowledge and perception on male partner involvement among women delivering at Coast Level Five Hospital.

2.6 Influence of the respondents’ cultural beliefs and reproductive health policy awareness on male partner involvement in choice of delivery site

2.6.1 Influence of the respondents' cultural beliefs on male partner involvement in choice of delivery site

Cultural beliefs of male partners contribute to non-participation of men in pregnancy and childbirth (Nanjala et al., 2012). Traditional or current gender norms that mitigate against male involvement are common in many communities. For example in Bangladesh, the belief that it is unnecessary or inappropriate for a man to be actively involved during pregnancy and postpartum, feeling shy, embarrassed and ‘out of place’ are common barriers (Story et al., 2012).

In Democratic Republic of Congo, in addition to gender norms, many communities attach stigma to men participating in activities thought of as ‘women’s business’ or to visiting clinics where sick people attend (Natoli et al., 2012). In Malawi, studies conducted in Kafue and Chilanga, where women have generally expressed interest in their partners’ involvement in clinic-based activities except during childbirth due to traditional culture in which only women are allowed to support during labour and childbirth (Phiri, 2011).
Onyango et al., (2010) revealed that the existing gender norms among cultures in Western Kenya influence and determine the extent of male involvement in reproductive health. In Western Kenya, as in many parts of the country, childbirth and child rearing are traditionally women’s responsibilities. In his role as the head of the household, the man in the family is not expected to discuss matters of sexuality with his female children. This cultural belief not only protects men from discussing issues of reproductive health; it contributes to the general lack of male involvement in reproductive health. Despite the available literature, little is known about the influence of cultural beliefs on male partner involvement in choice of delivery site at Coast Level Five Hospital. This study established the influence of cultural beliefs on involvement in choice of delivery site.

2.6.2 Influence of the respondents’ awareness of reproductive health policy on male partner involvement in choice of delivery site

Though men are not direct beneficiaries of safe motherhood services, their understanding and participation and support is crucial in order for women to access basic reproductive health services (Kura et al., 2013). A study in New Papua Guinea established that awareness and education on safe motherhood initiatives have never been targeted at men. Husbands were only informed when their wife encountered problems associated with pregnancy. Therefore many men in this study considered safe motherhood to be women’s responsibility (Kura et al., 2013).

In Nepal it was established that health providers’ interaction with husbands was fairly limited, given the hospital’s restrictions on husbands’ entrance into most areas of the hospital and relatively short hours of operation (Mullany, 2006).
In Uganda, the Ministry of Health has a policy that supports male involvement in reproductive health (Kaye et al., 2013). This policy is in place at Mulago hospital, a referral and teaching hospital in Uganda. In a study at Mulago hospital, the participants were of the view that it was apparent that they were expected to participate and be actively involved in the healthcare of their spouses (Kaye et al., 2013). Despite the existence of a supportive policy for male involvement, men experience stressful situations in their attempts to be involved during pregnancy and childbirth. The study revealed that there is a dissonance between the policy for male involvement and the practice in the health system. The men realize that the health system’s policy (that advocates for male involvement), and the contemporary societal expectations (that men should be as involved as possible in pregnancy, birth and childrearing) contrast sharply with the reality (Kaye et al., 2013).

The Kenya national reproductive health policy of 2007 identified promotion of male involvement in reproductive health programmes as key in improving maternal and neonatal health (GOK, 2007). While this policy has been in place since 2007, it appears that some people may not be aware of its existence and importance. In a study in Western Kenya by Onyango et al., (2010), it established that majority of participants stated that the government should have a male RH policy. The participants further argued that the policy should state among other things that anytime a woman is pregnant she should be told that the husband must attend the clinic, may be a law that would compel men to accompany their female partners to the clinic—especially when pregnant and in addition, the government to take the initiative to teach the men that RH is not just about women and children.
Despite the available literature review, the influence of cultural beliefs and reproductive health policy awareness on male partner involvement among women delivering at Coast Level Five Hospital remains unknown. As such, the current study established the influence of cultural beliefs and reproductive health policy awareness on male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital.

2.7: Conceptual framework

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Dependent variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women &amp; male partners’ Knowledge and perceptions on male involvement</td>
<td>Male partner involvement in choice of delivery site</td>
</tr>
<tr>
<td>Women and male partners’ Socio-demographic factors</td>
<td></td>
</tr>
<tr>
<td>(Age &amp; education)</td>
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<tr>
<td>Women &amp; male partners’ Cultural beliefs</td>
<td></td>
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<tr>
<td>Women &amp; male partners’ Economic factors</td>
<td></td>
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<tr>
<td>(Income)</td>
<td></td>
</tr>
<tr>
<td>Women &amp; male partners’ awareness of Reproductive Health Policies</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2.1 conceptual framework

Source: Adopted with modification from Nantamu (2011)
2.8 Theoretical Framework

The Health Belief Model (HBM) explains the factors that influence one to taking a health related action. The model comprises of three concepts; individual perception, modifying factors and likelihood of taking an action and four health beliefs (related factors) which influence health behaviour namely: perceived susceptibility; perceived risk; perceived benefits and perceived barriers. The HBM assumes that a person takes a health-related action if that person perceives that he/she is susceptible to a serious or severe health consequence (individual factor) and feels that a negative health condition can be avoided.

Prior experience with a serious condition, knowledge of a condition, peer or social pressure would help the person perceive that she/he might be susceptible to a health condition. This also helps to perceive the threat of not taking the required action and see benefits of taking a recommended health action to avoid a negative health condition. This activates the readiness and stimulates overt behaviour to overcome barriers to taking a health related action. Cues to action (like education, information and having symptoms of a condition) acts as reminders, also promotes perceived risk then this leads to likelihood of taking a recommended health action (Glanz et al., 2009).

In this study, it was suggested that prime motivation for the male partner to be involved in choice of delivery site would be if they perceive that their women are susceptible to bad pregnancy outcomes / serious pregnancy conditions. In addition, the perceived threat of adverse maternal or neonatal outcome could motivate the male partner to be involved. Prior experiences such as consequences of previous delay in making a decision to seek health care or access the care could affect how the male partners perceive susceptibility, severity, benefits and barriers. A male partner who
believes that being involved in choice of delivery site is beneficial to prevent adverse pregnancy and neonatal outcomes identify their barriers to their involvement (like cultural beliefs, community perceptions, religion, gender norms, lack of knowledge and unawareness of reproductive health policy) and explore ways to eliminate or reduce these barriers.

ANC education, information, mass media communication on male involvement in RH services and its benefits acts as a reminder and facilitate the likelihood of involvement. Positive perceptions of male partner involvement in maternal and neonatal health can trigger the decision making process whereby perceived barriers and benefits are weighed against each other and a decision is made on involvement.
CHAPTER THREE: MATERIALS AND METHODS

3.1 Introduction

This chapter specifies and presents the materials and methods used in assessing male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital, Mombasa County. It gives the overall research process including the design, sampling procedure, the research tools, how the data was collected, managed and the presentation of the findings.

3.2 Research design

This research was a descriptive cross-sectional study.

3.3 Research variables

3.3.1 Dependent variables

The dependent variable was male involvement in choice of delivery site. This was measured based on whether the male partner discussed with the spouse on where to deliver, together chose the delivery site and the male partner provided the necessary logistical support to the spouse to access the chosen delivery site. Where the male partner participated in the mentioned activities, he was deemed to have been involved and vice versa.

3.3.2 Independent variables

The dependent variables were women and male partners’ socio-demographic and economic factors i.e. educational level, religion, age and income; Knowledge and perceptions; cultural beliefs and awareness of the reproductive health policy. The respondents’ knowledge was measured based on their knowledge of the concept of
male partner involvement in choice of delivery, awareness of the need for male involvement, whether it is necessary and its benefits. Each correct response to a question was awarded a score whereas zero to an incorrect response. The individual cumulative score was used to obtain a mean score for women and male partners. The mean scores were used as the cut-off for good and poor knowledge. Those with scores equal to or more than the mean were regarded as having good knowledge while those with scores below the mean scores as having poor knowledge.

As with knowledge, perception of the respondents was measured based on how they perceived male partners accompanying the spouses to ANC, discussing maternal health issues (FP, ANC etc), participating in choice of delivery site, and escorting the spouse to the chosen delivery site. The likert scale with scores ranging from 0=strongly disagree to 5=strongly agree was used. The cumulative scores for male partners and women respondents were obtained separately. The mean scores were obtained and then used as cut-offs for good and poor perception. All the respondents with cumulative scores equal or more than the mean were regarded as having good perceptions while those with scores below the mean were regarded as having poor perception.

Cultural beliefs were measured based on whether the respondents had cultural beliefs that prohibited male involvement in choice of delivery (with Yes=cultural beliefs present and No= no cultural beliefs) and were able to state these beliefs. Awareness of reproductive health policy was measured based on whether the respondents were aware (Yes=aware, No= not aware) of the RH policy that promoted male involvement in RH activities and positively identified the policy.
3.4 Location of the study

This study was conducted at the post natal ward (PNW) at Coast Level Five Hospital, Mombasa County. The ward has a capacity of 60 beds. This hospital was purposely selected because it is the largest and the main referral hospital in the entire coast region. More maternal deaths occur at this facility compared to other health facilities in the county. According to the district health information system (DHIS 2), out of 152 maternal deaths reported in the county in 2011 and 2012, 109 (71.7%) occurred at Coast Level Five Hospital.

Coast Level Five Hospital is a 672 bed capacity hospital situated at Tononoka area in Mombasa County along Mombasa –Kilifi highway. It was founded in 1908 as a native civil hospital. It serves about 800,000 within its primary catchment area and more than 3 million from the secondary catchment area. Coast Level Five Hospital is the main teaching hospital in Coast region. It provides curative, rehabilitative, promotive and preventive health services. The major departments in his hospital are surgery, maternity, paediatrics, medical, radiography, pharmacy, laboratory, MCH among others (GOK, 2012).

Mombasa is the second largest city in Kenya (Appendix 1). Located on Kenya's Eastern coastline bordering the Indian Ocean, its original Arabic name is Manbasa. In Kiswahili, it is called "Kisiwa Cha Mvita", which means "Island of War" due to the many changes in its ownership. Mombasa has a population of 939, 370 and covers an area of 218.86 square kilometres. Mombasa County comprises of four sub-counties namely: Kisauni, Likoni, Kilindini and Mombasa. It has six constituencies; these are;
Likoni, Mvita, Nyali, Kisauni, Chomvu and Changamwe. It is inhabited by the Mijikenda, Arabs and upcountry migrants, among others (GOK, 2012).

3.5 Study population
Women who had delivered at Coast Level Five Hospital, Mombasa County and their male partners comprised the study population. It is estimated that about 450 pregnant women with normal pregnancy deliver at Coast Level Five Hospital per month.

3.6 Sampling techniques and sample size
3.6.1 Sampling techniques
The study location was selected purposively. Systematic sampling was used to select the respondents. On average, 450 women deliver at Coast Level Five Hospital per month. After delivery, the women are admitted to the postnatal ward. The admission register at the postnatal ward was used to generate a sampling frame. Because data collection took one month, the average number of deliveries per month was divided by the sample size (450/207). This resulted to every 2nd woman being selected. However, only those who met the set criteria were selected to participate in the study. If a woman selected as a 2nd participant did not meet the criteria, she was dropped and the next one picked and also assessed on the same criteria and were then either interviewed or dropped. Once the woman was picked, the male partner automatically qualified to participate. However, if the male partner decided not to participate because of whatever reason, the couple was omitted. This process was repeated until the desired sample size was attained. Simple random was used to identify the first respondent from the sampling frame to be interviewed and for participant of FGD’s. The researcher wrote each woman’s number as they appeared on the sampling frame and randomly picked one. The woman’s whose number was picked was the first to be interviewed.
3.6.2 Sample size

The sample size was determined using this formula by Fisher et al., (1998).

\[ n = \frac{z^2 \times p \times q}{d^2} \]

Where: 
- \( n \) = desired sample size (if target population is greater than 10,000)
- \( z \) = standard normal deviate at required confidence level. (1.96) corresponds to 95% confidence interval.
- \( p \) = the proportion in the target population estimated to have the characteristic being measured. (Because it was unknown, 0.5 was used).
- \( q = 1 - p \) (0.5)
- \( d \) = the level of statistical significance (0.05)
\[ n = \frac{1.96 \times 1.96 \times 0.5 \times 0.5}{0.05 \times 0.05} \]
\[ = 384 \]

Because the population was less than 10,000, the final samples estimate (\( n_f \)) was calculated as follows:

\[ n_f = \frac{n}{1+n} \times \frac{N}{N} \]

Where: 
- \( n_f \) = the desired sample size (when the population is less than 10,000)
- \( n \) = the desired sample size (when the population is more than 10,000)
- \( N \) = estimate of the population size.
\[ n_f = \frac{384}{1+384} \times \frac{450}{450} \]
\[ = 207 \]

3.7 Inclusion and exclusion criteria

3.7.1 Inclusion criteria

The women must have delivered at Coast Level Five Hospital. Couples who were married or who were in any informal union and were willing to participate in the study
were included. Additionally, the spouses were physically and emotionally stable enough to respond well were included. Pre-interview assessment to gauge whether the women respondents had recovered well from the labour process was done by the research team. Questions on how the woman and the baby were faring on after delivery, any concerns they had concerning their welfare and the partners were used to assess the physical and emotional status. Their responses were used to determine whether they were fit for interview.

3.7.2 Exclusion criteria

All those women who did not deliver at Coast Level Five Hospital were excluded. Single women or divorced, widowed or separated during the current delivery were not included in this study. Those who were unwilling to participate and those who were emotionally and physically unstable to respond well were also excluded.

3.8 Data collection tools and pre-testing

Quantitative data was collected using a semi-structured interviewer administered questionnaire (Appendix 2), while qualitative data was collected by focus group discussion guide (Appendix 4&5). A pre-test was carried out at Port Reitz District Hospital PNW, which was selected purposively because it admitted patients with similar characteristics as those admitted at Coast Level Five Hospital. The pre-test involved 5 couples who met the criteria that were used during the main research. The questionnaire was administered; short focus group discussions (FGDs) of 30 minutes were carried out separately involving 2 women who have delivered at the facility and 2 male partners whose women delivered there. The obtained data was analysed and
findings used to improve the questionnaire as vague words were removed, questions that were misunderstood were revised and some were omitted.

3.9 Recruitment and training of research assistants

Four third year nursing students from KMTC Mombasa campus were recruited to assist in data collection. The third year nursing students were chosen because they had covered research in their course and were therefore easy to train. In addition, they were in rotation in maternity. The training was conducted for one day and covered the overall research design, communication skills, interviewing and recording, how to obtain informed consent and ethics in research.

3.10 Data collection procedure

Data was collected at post natal ward from women and their male partners after delivery. The study was explained in detail to the women and the male partners who were present at the ward seeking their consent. The male partners who were away were contacted by the researcher over the phone and convenient time to meet was agreed. The research team met with potential respondents at post natal ward. The study was explained in detail and their consent was then sought. The interviews for the women and the male partners were conducted separately to avoid influence from either party in responding.

The researcher and the assistants recorded the responses on the questionnaires as provided. The questionnaires were checked for completeness and if they were not complete, corrections were done before the respondents were released. Each research
assistant handed their filled questionnaires to the researcher at the end of each day for cleaning and storage.

A Separate focus group discussion was conducted for the women who had delivered and admitted at the post natal ward and male partners who met the inclusion criteria. Each focus group discussion had 6 members each. The FGDs were done after the administration of the questionnaires. The participants of the FGDs were different from those who were interviewed. The FGDs were carried out at the lactation centre for the women and at the hospital boardroom for male partners respectively. The FGDs were moderated by this researcher and a research assistant who assisted with tape recording and note taking. A focus discussion guide was used when conducting the discussions. The discussions concentrated on the level of male partner involvement, knowledge and perception, cultural and reproductive policies awareness and their influence on male partner involvement. Each FGD took one and half hours.

3.11 Logistical and ethical consideration

This researcher sought authority to conduct the research from Kenyatta University graduate school (Appendix 7). Ethical clearance was obtained from Kenyatta University ethics review committee (KU-ERC) (Appendix 8) and a research permit was obtained from National Commission for Science, Technology and Innovation (NACOSTI) (Appendix 9). The hospital authority was requested to conduct the research in the hospital (Appendix 10). Informed consent was sought from the respondents willing to participate after fully explaining to them the whole research process, benefits and risks and their rights in participation (Appendix 11). Confidentiality was maintained and anonymity was ensured as there was no form of identification to protect the respondents.
3.12 Data analysis

Quantitative data was analysed using the computer software Statistical Package for Social Sciences (SPSS) version 16. Knowledge was measured using a set of questions in which the correct response was awarded 1 score while wrong response a zero. The total score from all the respondents in that category was used to get the mean score. Scores that were equal to or above the mean were regarded as good knowledge and those below the mean as poor knowledge.

Perception level was determined based on the respondents’ perception of male partner involvement in the four RH-related activities using the likert score. The cumulative scores of women and male partners obtained separately were used to obtain the mean score. All those scores that were equal or above the mean score were regarded as representing good perception and those below the mean score as poor perception.

Frequencies were used to describe the findings. Chi-square was used to test the association of categorical variables. Logistic regression was used for estimating association of potential predictors of male partner involvement. To establish the influence of change of an independent variable on the dependent variable, marginal effects were obtained after logistic regression using STATA version 13. The findings were presented using tables, bar graphs, pie charts and text.

The qualitative data that was tape-recorded was transcribed and analysed for content with similar categories grouped into sub-themes and themes. Results were presented as direct quotes from participants or as narrations. These results were finally triangulated with the quantitative data. All p-values $\leq 0.05$ were considered statistically significant.
CHAPTER FOUR: RESULTS

4.1 Introduction

This chapter presents the results of male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital, Mombasa County. These results provide details on the level of male partner involvement, the socio-demographic and economic factors influencing male partner involvement, the influence of knowledge, perception, cultural beliefs and awareness of reproductive health policy on male partner involvement.

4.2 Socio-demographic and economic characteristics of the respondents

Socio-demographic and economic characteristics of the respondents are shown in Table 4.1. Most women and their male partners were aged 20-30 years (73.9% and 55.6% respectively). While no male partner was below 20 years, no woman respondent was aged above 40 years. The results show no much difference in proportions of religious affiliation among the respondents. Most women and male partners were Protestants (47.8% and 45.9%, respectively) then followed by Muslims adherents at 28.5% of women and 28% of men.

Compared to women respondents, male partners had better education. While most women respondents (50.7%) had primary education and below, most of the male partners had secondary education and above. Only 17.4% of the women had post-secondary education compared to 22.7% of the male partners.

Generally, male partners earned more money than the women. While most of the male partners earned more than KShs. 5,000 per month, most women respondents (66.0%) earned less than KShs. 5,000 per month. Most of the couples (93.2%) were in monogamous marriage and 6.8% were in polygamous marriages.
Table 4.1: Socio-demographic and economic factors of the respondents

<table>
<thead>
<tr>
<th>Variables</th>
<th>N=207 Women, n (%)</th>
<th>N=207 Male partners, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 20 years</td>
<td>19 (9.2)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>20-30 years</td>
<td>153 (73.9)</td>
<td>115 (55.6)</td>
</tr>
<tr>
<td>31-40 years</td>
<td>35 (16.9)</td>
<td>73 (35.3)</td>
</tr>
<tr>
<td>Above 40 years</td>
<td>0 (0.0)</td>
<td>19 (9.1)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>59 (28.5)</td>
<td>58 (28.0)</td>
</tr>
<tr>
<td>Catholic</td>
<td>46 (22.3)</td>
<td>43 (20.8)</td>
</tr>
<tr>
<td>Protestant</td>
<td>99 (47.8)</td>
<td>95 (45.9)</td>
</tr>
<tr>
<td>None / ATR</td>
<td>3 (1.4)</td>
<td>11 (5.3)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school level and below</td>
<td>105 (50.7)</td>
<td>79 (38.2)</td>
</tr>
<tr>
<td>Secondary</td>
<td>66 (31.9)</td>
<td>81 (39.1)</td>
</tr>
<tr>
<td>Post-secondary</td>
<td>36 (17.4)</td>
<td>47 (22.7)</td>
</tr>
<tr>
<td><strong>Income (Per month, KShs.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below 5,000</td>
<td>136 (65.7)</td>
<td>26 (12.6)</td>
</tr>
<tr>
<td>5,000 - 10,000</td>
<td>37 (17.9)</td>
<td>60 (29.0)</td>
</tr>
<tr>
<td>10,001 - 15,000</td>
<td>21 (10.1)</td>
<td>45 (21.7)</td>
</tr>
<tr>
<td>15,001 - 20,000</td>
<td>6 (2.9)</td>
<td>34 (16.4)</td>
</tr>
<tr>
<td>20,001 - 25,000</td>
<td>2 (1.0)</td>
<td>18 (8.7)</td>
</tr>
<tr>
<td>Above 25,000</td>
<td>5 (2.4)</td>
<td>24 (11.6)</td>
</tr>
<tr>
<td><strong>Type of marriage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monogamous</td>
<td>193 (93.2)</td>
<td></td>
</tr>
<tr>
<td>Polygamous</td>
<td>14 (6.8)</td>
<td></td>
</tr>
</tbody>
</table>
4.3 Male partner involvement in choice of delivery site

4.3.1 Previous deliveries and site of delivery

The delivery records and site of delivery of the women are presented in Table 4.2. The findings revealed that 56.5% of women interviewed had delivered previously and 43.5% of the women were delivering for the first time. Of the women who had delivered previously, majority of them (68.6%) had delivered 1-2 children in their lifetime. Public hospitals were the most preferred places of delivery with 47.9% of women having delivered there. However, a significant proportion of women (26.5%) delivered at home.

<table>
<thead>
<tr>
<th>Parity and site of delivery of the women</th>
<th>N=207</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deliveries in lifetime</td>
<td>Number of respondents (%)</td>
</tr>
<tr>
<td>1-2</td>
<td>142 (68.6)</td>
</tr>
<tr>
<td>3-4</td>
<td>51 (24.6)</td>
</tr>
<tr>
<td>&gt;4</td>
<td>14 (6.8)</td>
</tr>
<tr>
<td>Site of previous delivery</td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>31 (26.5)</td>
</tr>
<tr>
<td>Private clinic</td>
<td>10 (8.5)</td>
</tr>
<tr>
<td>Public dispensary/health centre</td>
<td>16 (13.7)</td>
</tr>
<tr>
<td>Public hospital</td>
<td>56 (47.9)</td>
</tr>
<tr>
<td>Private hospital</td>
<td>4 (3.4)</td>
</tr>
</tbody>
</table>
4.3.2 Level of male partners’ involvement in choice of Coast Level Five Hospital as the delivery site

In order to establish the level of male partner involvement in choice of delivery site, the women and male partners were asked whether the male partners were involved in discussing about the various delivery sites and jointly making a choice of the preferred delivery site. In addition, they were asked whether the male partners provided support to the women to access Coast Level Five Hospital. Their responses are shown in Table 4.3.

The findings established that majority of the women and male partners interviewed (59.4% each) said the male partners never discussed with the women on delivery site, did not jointly chose the delivery site nor supported the women to access Coast Level Five Hospital. However, 40.6% of women and male partners interviewed said the male partners discussed with them on delivery site, made a joint decision delivery site and supported them to access choice of Coast Level Five Hospital. This implies that the level of male partner involvement in choice of Coast Level Five Hospital 40.6%.

Table 4.3: The role of male partners in choice of Coast Level Five Hospital as delivery site

<table>
<thead>
<tr>
<th>Role played by male partner in choice of delivery site</th>
<th>N=207 Women n (%)</th>
<th>N=207 Male partners n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The male partner discussed with the spouse about delivery sites and jointly chose Coast Level Five Hospital</td>
<td>Yes 84 (40.6)</td>
<td>84 (40.6)</td>
</tr>
<tr>
<td></td>
<td>No 123 (59.4)</td>
<td>123 (59.4)</td>
</tr>
<tr>
<td>The male partner provided support to the spouse to access Coast Level Five Hospital</td>
<td>Yes 84 (40.6)</td>
<td>84 (40.6)</td>
</tr>
<tr>
<td></td>
<td>No 123 (59.4)</td>
<td>123 (59.4)</td>
</tr>
</tbody>
</table>
During women and male partners’ focus group discussions, the participants had different opinions on male partner involvement in the choice of delivery site. Although some members argued that male partners should be involved in choice of delivery site, others felt the decision should be made by the male partner alone while others were of the view that it should left to the woman alone. However, one male participant had a totally different view. According to him “The father in-law and the mother in-law both are involved in making the decision. As the husband I talk to the father in-law who consults with the mother in-law who gives her input. She has to be involved because of the cultural beliefs and practices in our community”

4.4 Socio-demographic and economic factors influencing male partner involvement in choice of delivery site

4.4.1 Women socio-demographic and economic factors influencing male partner involvement

The women socio-demographic and economic factors and their influence on male partner involvement in choice of delivery site are shown in Table 4.4. The study revealed that male partner involvement in choice of delivery site decreased with increase in women age. However, this was not statistically significant (p=0.432).

Women religious affiliation had no significant influence on male partner involvement (p=0.281). The women’s education level significantly influenced male partner involvement in choice of delivery site ($\chi^2$=17.090, df =2, P<0.001). Male partner involvement increased with increase in women level of education with the highest proportion being where women had post-secondary education (66.7%).
The study revealed that women income influenced male partner involvement ($\chi^2$-10.37, df-5, p=0.006). Male partners of women with higher income were more likely to be involved in choice of delivery site.

Table 4.4: Women socio-demographic and economic factors and male partner involvement

<table>
<thead>
<tr>
<th>Women characteristics</th>
<th>Categories</th>
<th>Male partner involvement</th>
<th>N=207</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Not involved n (%)</td>
<td>Involved n (%)</td>
</tr>
<tr>
<td>Age</td>
<td>Below 20 years</td>
<td>10 (52.6)</td>
<td>9 (47.4)</td>
</tr>
<tr>
<td></td>
<td>20-30 years</td>
<td>89 (58.2)</td>
<td>64 (41.8)</td>
</tr>
<tr>
<td></td>
<td>31-40 years</td>
<td>24 (68.6)</td>
<td>11 (31.4)</td>
</tr>
<tr>
<td>Religion</td>
<td>Muslim</td>
<td>40 (67.8)</td>
<td>19 (32.2)</td>
</tr>
<tr>
<td></td>
<td>Catholic</td>
<td>25 (54.3)</td>
<td>21 (45.7)</td>
</tr>
<tr>
<td></td>
<td>Protestant</td>
<td>56 (56.6)</td>
<td>43 (43.4)</td>
</tr>
<tr>
<td></td>
<td>None /ATR</td>
<td>2 (66.7)</td>
<td>1 (33.3)</td>
</tr>
<tr>
<td>Education level</td>
<td>Primary school level &amp; below</td>
<td>75 (71.4)</td>
<td>30 (28.6)</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>36 (54.5)</td>
<td>30 (45.5)</td>
</tr>
<tr>
<td></td>
<td>Post-secondary</td>
<td>12 (33.3)</td>
<td>24 (66.7)</td>
</tr>
<tr>
<td>Income- (per month, KShs.)</td>
<td>Below 5,000</td>
<td>91 (66.9)</td>
<td>45 (33.1)</td>
</tr>
<tr>
<td></td>
<td>5,000-10,000</td>
<td>14 (37.8)</td>
<td>23 (62.2)</td>
</tr>
<tr>
<td></td>
<td>10,001-15,000</td>
<td>12 (57.1)</td>
<td>9 (42.9)</td>
</tr>
<tr>
<td></td>
<td>15,001 -20,000</td>
<td>2 (33.3)</td>
<td>4 (66.7)</td>
</tr>
<tr>
<td></td>
<td>20,001 -25,000</td>
<td>1 (50.0)</td>
<td>1 (50.0)</td>
</tr>
<tr>
<td></td>
<td>Above 25,000</td>
<td>3 (60.0)</td>
<td>2 (40.0)</td>
</tr>
</tbody>
</table>
4.4.2 Male partners socio-demographic and economic factors and male partner involvement

Table 4.5 shows male partners’ socio-demographic and economic factors that influenced their male partner involvement in choice of delivery site. The study revealed that male partners’ age had no significant influence on male partner involvement (p=0.191). This implies that male partners of any age can be involved in choice of delivery site. In addition to age, the male partners’ religion had no significant influence on male partner involvement (p=0.451).

Education level of the male partners significantly influenced their involvement ($\chi^2=16.562$, df=2, $P<0.001$). The highest proportion of the male partners who were involved had post-secondary education (61.7%). The findings suggest that male partner involvement increased with increase in level of male partner education. Further, male partner income was significantly influenced their involvement ($\chi^2=12.974$, df=5, $p=0.024$). Male partners with high income were more likely to be involved compared to those with low income.
Table 4.5: Male partner socio-demographic and economic factors and male partner involvement

<table>
<thead>
<tr>
<th>Male characteristics</th>
<th>Categories</th>
<th>Male partner involvement</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Not involved n (%)</td>
<td>Involved n (%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N=207</td>
<td>χ²</td>
<td>df</td>
</tr>
<tr>
<td>Age</td>
<td>20-30 years</td>
<td>66 (53.4)</td>
<td>49 (42.6)</td>
<td>-3.309</td>
</tr>
<tr>
<td></td>
<td>31-40 years</td>
<td>42 (57.5)</td>
<td>31 (42.5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Above 40 years</td>
<td>15 (78.9)</td>
<td>4 (21.1)</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td>Muslim</td>
<td>38 (65.5)</td>
<td>20 (34.5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Catholic</td>
<td>24 (55.8)</td>
<td>19 (44.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protestant</td>
<td>53 (55.8)</td>
<td>42 (44.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>None /ATR</td>
<td>8 (72.7)</td>
<td>3 (27.3)</td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td>Primary school level &amp; below</td>
<td>59 (74.7)</td>
<td>20 (25.6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>secondary</td>
<td>46 (56.8)</td>
<td>35 (43.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>post-secondary</td>
<td>18 (38.3)</td>
<td>29 (61.7)</td>
<td></td>
</tr>
<tr>
<td>Income - (per month, KShs.)</td>
<td>Below 5,000</td>
<td>18 (69.2)</td>
<td>8 (30.8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5,000-10,000</td>
<td>41 (68.2)</td>
<td>19 (31.7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10,001-15,000</td>
<td>29 (64.4)</td>
<td>16 (35.6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15,001-20,000</td>
<td>19 (55.9)</td>
<td>15 (44.1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20,001-25,000</td>
<td>5 (27.8)</td>
<td>13 (72.2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Above 25,000</td>
<td>11 (45.8)</td>
<td>13 (54.2)</td>
<td></td>
</tr>
</tbody>
</table>
4.5 Influence of knowledge and perception on male partner involvement in choice of delivery site

4.5.1 Influence of knowledge of male partner involvement and its benefits

The questions and the responses of women and male partners presented in Table 4.6 and Table 4.7 respectively were used to assess the level of knowledge of the respondents on male partner involvement in choice of delivery site and its benefits. Each correct response to a question was awarded a mark whereas zero to an incorrect response. The cumulative score for each individual respondent were summed up and divided by the total number of women and male partner respondents separately to obtain the mean score for women and male partners’ respectively. The mean scores were used as the cut-off for good and poor knowledge.

4.5.1.1 Women knowledge of male partner involvement in choice of delivery site and its benefits

The results shown in Table 4.6 indicate that most women understood male partner involvement in choice of delivery site to mean the male partner and women discussing on delivery sites, jointly choose the delivery site and the male partner supporting the women to access the chosen site of delivery (51.7%). Of the women interviewed, 96.1% were aware of the need to involve male partners, 97.6% said it was indeed necessary to involve male partners and 27.5% argued that it was important to involve the partners so that in case of complications they will assist early enough.
Table 4.6: Women knowledge of male partner involvement in choice of delivery site and its benefits

<table>
<thead>
<tr>
<th>Meaning, awareness and importance of male partner involvement</th>
<th>N=207 (n)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. The meaning of male partner involvement in choice of delivery site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) The male partner alone deciding the site of delivery</td>
<td>73</td>
<td>35.3</td>
</tr>
<tr>
<td>b) The woman and the male partner discussing, jointly choose the site</td>
<td>107</td>
<td>51.7</td>
</tr>
<tr>
<td>c) The male partner supporting the woman to access delivery site</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>d) The woman deciding alone and informing the male partner</td>
<td>22</td>
<td>10.6</td>
</tr>
<tr>
<td><strong>2. Aware of the need to have male partners involved in choice of delivery site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) No</td>
<td>8</td>
<td>3.9</td>
</tr>
<tr>
<td>b) Yes</td>
<td>199</td>
<td>96.1</td>
</tr>
<tr>
<td><strong>3. It is necessary /important to involve male partners in Choice of the delivery site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) No</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>b) Yes</td>
<td>202</td>
<td>97.6</td>
</tr>
<tr>
<td><strong>4. The importance/benefit of male partner involvement in choosing the delivery site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) None stated / involvement not necessary</td>
<td>14</td>
<td>6.7</td>
</tr>
<tr>
<td>b) For logistical support before and after delivery e.g. money, transport</td>
<td>36</td>
<td>17.4</td>
</tr>
<tr>
<td>c) Incase of problems/complications he can assist early enough</td>
<td>57</td>
<td>27.5</td>
</tr>
<tr>
<td>d) For safe and quality services during delivery as he will follow the labour progress and assist as necessary</td>
<td>13</td>
<td>6.3</td>
</tr>
<tr>
<td>e) The male partner is household head this is done as a sign of respect</td>
<td>45</td>
<td>21.7</td>
</tr>
<tr>
<td>f) Pregnancy and childbirth is for both therefore the partner should be involved and support the woman for good outcome</td>
<td>39</td>
<td>18.8</td>
</tr>
<tr>
<td>g) The male partner is more knowledgeable and is able to help</td>
<td>3</td>
<td>1.4</td>
</tr>
</tbody>
</table>
4.5.1.2 Level of women knowledge of male partner involvement and its benefits

To determine the level of women knowledge of male partner involvement and its benefits, a score was awarded to each correct response to the four questions and zero for a wrong response. The cumulative scores were then used to obtain the mean score which was used as the cut-off for good and poor knowledge. The mean score for women respondents was 3.15 out of the possible 4. All respondents with a score equal to or above the mean were regarded to have good knowledge while those with scores below the mean were regarded to have poor knowledge.

The level of women knowledge of male partner involvement and its benefits is shown in Figure 4.1. The study showed that most of the women interviewed (60.1%) had poor knowledge of male partner involvement in choice of delivery site and its benefits while 39.1% had good knowledge. However, women participants in the FGD had different levels of knowledge of male partner involvement. Although some women had good knowledge, majority of them had poor knowledge. One woman in the focus group discussion understood male partner involvement to mean “The male partner should decide where to deliver”. Another one in the same group said “The wife decides where to deliver and informs the husband”.
Figure 4.1: Level of women knowledge of male partner involvement and its benefits

4.5.1.3 Male partner knowledge of male partner involvement and its benefits

The male partners’ responses to questions assessing their knowledge on male partner involvement are presented in Table 4.7. Of male partners interviewed, 51.0% understood male partner involvement to mean the male partner and the woman discussing on delivery site, jointly choosing a delivery and the male partner supporting the woman to access the chosen delivery site, 93.2% said they were aware of the need for male partners being involved in choosing the delivery site, 96.1% felt it was important to involve male partners in choosing the delivery site and 21.3% argued that because male partners are household heads, they should be involved as a sign of respect.
Table 4.7: Male partners’ knowledge of male partner involvement and its benefits

<table>
<thead>
<tr>
<th>Meaning, awareness and importance of male partner involvement</th>
<th>N=207 (n)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. The meaning of male partner involvement in choice of delivery site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) The male partner alone choosing the site of delivery</td>
<td>65</td>
<td>31.4</td>
</tr>
<tr>
<td>b) The woman and the male partner jointly discussing and choosing delivery site and male partner supporting the woman to access for chosen delivery site.</td>
<td>118</td>
<td>57.0</td>
</tr>
<tr>
<td>c) The male partner and his brothers/parents choosing delivery site alone</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>d) The woman choosing the delivery site alone and informing the male partner</td>
<td>6</td>
<td>2.9</td>
</tr>
<tr>
<td>e) No idea</td>
<td>14</td>
<td>6.8</td>
</tr>
<tr>
<td><strong>2. Aware of the need to have male partner involved in choosing the delivery site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) No</td>
<td>14</td>
<td>6.8</td>
</tr>
<tr>
<td>b) Yes</td>
<td>193</td>
<td>93.2</td>
</tr>
<tr>
<td><strong>3. It is necessary/important to involve male partners in choosing the delivery site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) No</td>
<td>8</td>
<td>3.9</td>
</tr>
<tr>
<td>b) Yes</td>
<td>199</td>
<td>96.1</td>
</tr>
<tr>
<td><strong>4. The importance/benefit of male partner involvement in choice of delivery site?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) None stated / involvement is not necessary</td>
<td>25</td>
<td>12.1</td>
</tr>
<tr>
<td>b) For logistical support before and after delivery e.g. money, transport</td>
<td>30</td>
<td>14.5</td>
</tr>
<tr>
<td>c) Incase of problems/complications he can assist early enough</td>
<td>31</td>
<td>15.0</td>
</tr>
<tr>
<td>d) For safe and quality services during delivery as he follow labour progress and assist as necessary</td>
<td>42</td>
<td>20.3</td>
</tr>
<tr>
<td>e) The male partner is household head this is done as a sign of respect</td>
<td>44</td>
<td>21.3</td>
</tr>
<tr>
<td>f) Pregnancy and childbirth is a concern to both therefore the partner should support the woman for good outcome</td>
<td>30</td>
<td>14.5</td>
</tr>
<tr>
<td>g) The male partner is more knowledgeable and is able to help</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>h) It makes it easy follow advice given by health workers</td>
<td>2</td>
<td>1.0</td>
</tr>
</tbody>
</table>
4.5.1.4 Level of male partners’ knowledge of male partner involvement and its benefits

To determine the level of male partners’ knowledge on male partner involvement and its benefits, a score was awarded to each correct response to the four questions and zero for a wrong response. The cumulative scores were then used to obtain the mean score which was used as the cut off for good and poor knowledge. The mean score of male partners was 3.12 out of the possible 4. All those male partners with a score equal to or above the mean were regarded as having good knowledge while those with scores below the mean were regarded as having poor knowledge.

Figure 4.2 shows the level of male partners’ knowledge on male partner involvement in choice of delivery site and its benefits. Results indicate that 62.3% of the male partners had poor knowledge while 37.7% had good knowledge. In addition, most male partners in the FGD had poor knowledge.

![Figure 4.2 Level of male partners’ knowledge on male partner involvement](image)
4.5.1.5 Influence of the level of the respondents’ knowledge of male partner involvement on male partner involvement of choice of delivery site

4.5.1.5.1 Level of women knowledge of male partner involvement and male partner involvement in choice of delivery site

The influence of the level of women knowledge on male partner involvement in choice of delivery site is presented in Table 4.8. The study established that when women had good knowledge, 59.3% of their male partners were involved in choice of delivery site compared to 28.6% when women had poor knowledge. The level of women knowledge had significant influence on male partner involvement in choice of delivery site ($\chi^2$= 19.256, df = 1, $P<0.001$)

**Table 4.8: Level of women knowledge and male partner involvement in choice delivery site**

<table>
<thead>
<tr>
<th>Knowledge level</th>
<th>Male involvement</th>
<th>$\chi^2$</th>
<th>df</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not involved n (%)</td>
<td>Involved n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor knowledge</td>
<td>90 (71.4)</td>
<td>36 (28.6)</td>
<td>19.256</td>
<td>1</td>
</tr>
<tr>
<td>Good knowledge</td>
<td>33 (40.7)</td>
<td>48 (59.3)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.5.1.5.2 Level of male partners’ knowledge of male partner involvement and male partner involvement in choice of delivery site

The level of male partner knowledge and its influence on male partner involvement in choice of delivery site is shown in Table 4.9. The study revealed that despite 46.2% of male partners with good knowledge and 37.2% of male partners with poor knowledge of male partner involvement in choice of delivery site being involved in choice of
delivery site, male partners’ level of knowledge did not influence male partner involvement in choice of delivery site ($\chi^2=1.613$, df 1, $p=0.204$).

Table 4.9: Level of male partners’ knowledge and male partner involvement in choice of delivery site

<table>
<thead>
<tr>
<th>Knowledge level</th>
<th>Male involvement</th>
<th>$\chi^2$</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not involved</td>
<td>Involved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor knowledge</td>
<td>81 (62.8)</td>
<td>48 (37.2)</td>
<td>1.613</td>
<td>1</td>
</tr>
<tr>
<td>Good knowledge</td>
<td>42 (53.8)</td>
<td>36 (46.2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.5.2 Influence of the respondents’ level of perception of male partner involvement in selected in RH-related activities on male partner involvement in choice of delivery site

In order to ascertain the respondents’ level of perception on male partner involvement in choice of delivery site, the respondents were asked to give their perception of male partners involved in selected reproductive health (RH) related activities: accompanying the spouses to ANC, discussing maternal health issues (FP, ANC etc), participating in choice of delivery site, and escorting the spouse to the chosen delivery site. Tables 4.10 and 4.11 show the women and male partners’ perceptions respectively. The likert scale with scores ranging from 0=strongly disagree to 5=strongly agree was used. The cumulative scores for male partners and women respondents were obtained separately. The scores were then used to obtain the mean score. All the respondents with cumulative scores equal or more than the mean were regarded as having good perceptions while those with scores below the mean were regarded as having poor perception.
4.5.2.1 Level of women perception of male partner involvement in RH-related activities

The perception of women of male partners’ involvement in RH-related activities is shown in Table 4.10. The mean score for women respondents obtained was 16.3. Using the mean score as the cut-off, the study found that 76.0% of women interviewed had poor perception while 24.0% of the women had good perception.

Table 4.10: Women perception of male partner involvement in selected RH activities

<table>
<thead>
<tr>
<th>The male partner should:</th>
<th>N=207</th>
<th>Strongly disagree n (%)</th>
<th>Disagree n (%)</th>
<th>Undecided n (%)</th>
<th>Agree n (%)</th>
<th>Strongly agree n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Accompany spouse to ANC</td>
<td>0 (0.0)</td>
<td>8 (3.9)</td>
<td>8 (3.9)</td>
<td>157 (75.8)</td>
<td>34 (16.4)</td>
<td></td>
</tr>
<tr>
<td>2. Discuss maternal health issues (FP, ANC etc)</td>
<td>0 (0.0)</td>
<td>3 (1.4)</td>
<td>6 (2.9)</td>
<td>160 (77.3)</td>
<td>38 (18.4)</td>
<td></td>
</tr>
<tr>
<td>3. Participate in choosing the delivery site</td>
<td>0 (0.0)</td>
<td>5 (2.4)</td>
<td>3 (1.4)</td>
<td>176 (85.0)</td>
<td>23 (11.1)</td>
<td></td>
</tr>
<tr>
<td>4. Escort spouse to the delivery site</td>
<td>0 (0.0)</td>
<td>7 (3.4)</td>
<td>2 (1.0)</td>
<td>166 (80.2)</td>
<td>32 (15.5)</td>
<td></td>
</tr>
</tbody>
</table>

4.5.2.2 Level of male partners’ perception of male partner involvement in selected RH-related activities

The perception of male partner is shown in Table 4.11. The mean score obtained was 16.4 out of the maximum mean score 20. Using the mean score as the cut off, the study revealed that 67.0% and 33.0% of male partners interviewed had poor and good perception of male partners involved the selected RH-related activities respectively.
Table 4.11: Male partner perception of male partner involvement in selected RH activities

<table>
<thead>
<tr>
<th>The male partner should:</th>
<th>N=207</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly disagree n (%)</td>
</tr>
<tr>
<td>1. Accompany spouse to ANC</td>
<td>4 (1.9)</td>
</tr>
<tr>
<td>2. Discuss maternal health issues (FP, ANC)</td>
<td>6 (2.9)</td>
</tr>
<tr>
<td>3. Participate in choosing the delivery site</td>
<td>6 (2.9)</td>
</tr>
<tr>
<td>4. Escort spouse to delivery site</td>
<td>7 (3.4)</td>
</tr>
</tbody>
</table>

Most participants in both FGDs had good perception of male partners’ involvement in the selected RH-related activities. However, some participants reported cases of poor perception of male partners who were involved in the selected activities among members of their communities. An example of some negative attributes branded on male partners who were involved is “The husband’s family members see you as controlling the husband and so he listens to you more” said a female participant from Kisauni Sub-county. Some male participants also said that the wife is seen as being above the man or seen as a leader in that family.
4.5.2.3 Influence of the level of the respondents’ perception on male partner involvement in choice of delivery site

4.5.2.3.1 Level of women perception and male partner involvement in choice of delivery site

The findings in Table 4.12 present the association between the level of women perception and male partner involvement. The study established that where women had good perception of male partner involved in RH-related activities, 61.2% of male partners were involved in choice of delivery site while where women had poor perception only 34.2% of male partners were involved. Women perception was significantly associated with male partner involvement in choice of delivery site ($\chi^2=11.347$, df-1 $p=0.001$).

Table 4.12: Level of women perception and male partner involvement in choice of delivery site

<table>
<thead>
<tr>
<th>Level of women Perception</th>
<th>Male involvement</th>
<th>$\chi^2$</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=207</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not involved n (%)</td>
<td>Involved n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor perception</td>
<td>104 (65.8)</td>
<td>54 (34.2)</td>
<td>11.347</td>
<td>1</td>
</tr>
<tr>
<td>Good perception</td>
<td>19 (38.8)</td>
<td>30 (61.2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.5.2.3.2 Level of male partner perception and their involvement in choice of delivery site

Level of male partner perception and their involvement are shown in Table 4.13. The study established that while 56.6% of male partners with good perception of male partners involved in selected RH-related activities were involved, only 32.6% of male
partners with poor perception were involved in choice of delivery site. Male partner perception significantly influenced male partner involvement in choice of delivery site ($\chi^2-10.909$, df-1, p=0.001).

Table 4.13: Level of male partner perception and male partner involvement in choice of delivery site

<table>
<thead>
<tr>
<th>Level of male partner perception</th>
<th>Male involvement</th>
<th>$\chi^2$</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not involved n (%)</td>
<td>Involved n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor perception</td>
<td>93 (67.4)</td>
<td>45 (32.6)</td>
<td>10.909</td>
<td>1</td>
</tr>
<tr>
<td>Good perception</td>
<td>30 (43.5)</td>
<td>39 (56.5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.6 Influence of the respondents’ cultural beliefs and awareness of reproductive health policy on male partner involvement in choice of delivery site

4.6.1 Influence of the respondents’ cultural beliefs on male partner involvement in choice of delivery site

4.6.1.1 Women cultural beliefs against male partner involvement in choice of delivery site

The results of this study indicated that 99.0% ($n=205$) of the women interviewed did not have any cultural beliefs against male partner involvement in choice of delivery site while 1.0% ($n=2$) had. Some women believed that women who deliver at home because of their culture do not involve their male partners in delivery related issues. In addition, most women in their FGD had no cultural beliefs against male partner involvement in choice of delivery site.
4.6.1.2 Male cultural beliefs against male partner involvement in choice of delivery site

While 97.1% (n=201) of male partners interviewed did not have cultural beliefs against male partner involvement in choice of delivery site, 2.9% (n=6) had them. Some of them believed that it was embarrassing for men to be involved in choice of delivery site; choice of delivery site was seen as women's work. Others believed it was the duty of old women to make decision on delivery site. In contrast, no participant in the male FGD had cultural beliefs against male involvement in choice of delivery site.

4.6.1.3 Influence of cultural beliefs on male partner involvement in choice of delivery site

This study revealed that very few women and male partners (2 and 5 respectively) had cultural beliefs concerning partner involvement in choice of delivery. With such figures this study could not conclusively establish the influence of women and male partner cultural beliefs on male partner involvement in choice of delivery site.

4.6.2 Influence of awareness of reproductive health policy on male partner involvement in reproductive health

4.6.2.1 Women awareness of reproductive health policy on male partner involvement reproductive health

The study revealed that 96.6% (n=200) of the women interviewed were not aware of any policy that promoted male partner involvement in reproductive health. Of the (3.4%, n=7) women who said they were aware of RH policy 57.1% (n=4) did not state the specific policy while 42.9% (n=3) cited the policy that required male partners to accompany their pregnant spouse to ANC and be involved in preparing a birth plan.
4.6.2.2 Male partners’ awareness of reproductive health policy on male partner involvement in reproductive health

Like their women counterparts, majority (96.1%, n=199) of male partners were not aware of any health policy supportive of male partner involvement in choice of delivery site. Among the male partners who said they were aware of a policy that promoted male involvement in RH, 87.5% (n=7) did not specify the policy while 12.5% (n=1) indicated their knowledge of the policy that required male partners to accompany their pregnant spouses to ANC and be involved in preparing a birth plan.

4.6.2.3 Influence of the respondents awareness of reproductive health policy on male partner involvement in choice of delivery

The study established that the respondents’ awareness of the reproductive health policy was very low. Even where the respondents said they were aware of the policy, most of them were unable to state the policy itself. Based on those two issues, it was hard to precisely determine the influence of awareness of reproductive health policy on male partner involvement in choice of delivery site.

4.7: Factors predicting male partner involvement in choice of delivery site

Logistic regression results of potential predictors of male partner involvement in choice of delivery site are presented in Table 4.14. The study results showed that among these factors, only women knowledge was a predictor of male partner involvement (p=0.003). This implies that the odds for a male partner whose spouse had good knowledge of male partner involvement and its benefits being involved were 2.6 times those of a partner whose spouse had poor knowledge.
Table 4.14: Predictors of male partner involvement in choice of delivery site

| Male involvement | OR   | z     | P>|z|  | [95% Conf. Interval] |
|------------------|------|-------|------|----------------------|
| Male education   | 1.337092 | 1.21  | 0.226  | 0.8355646 - 2.13965  |
| Women education  | 1.482535 | 1.53  | 0.125  | 0.8964047 - 2.451916 |
| Women income     | .9983253 | -0.01 | 0.992  | 0.7268663 - 1.371165 |
| Male income      | 1.145748 | 1.24  | 0.216  | 0.9236718 - 1.421216 |
| Women knowledge  | 2.637109 | 2.97  | 0.003  | 1.390611 - 5.000927  |
| Women perception | 1.526953 | 1.08  | 0.280  | 0.708011 - 3.293148  |
| Male perception  | 1.749707 | 1.61  | 0.108  | 0.8846919 - 3.460497  |
| _constant_       | 0664778   | -5.04 | 0.000  | 0.0231603 - 1908135   |

Key: OR=odds ratio, z = z-score for test, P>|z| = p-value for z-test

4.8 Effect of change in the independent variables on probability of male partner involvement in choice of delivery site

To determine the effect of change in the independent variables on the probability of male partner involvement, their marginal effects were obtained as shown in Table 4.15. The overall probability of these factors combined predicting male partner involvement was 39.5%. However, only improvement in women knowledge from poor to good could lead to significant increase in probability for male partner involvement in choice of delivery site. Holding all the other independent variables constant at their reference points (x), this change will significantly increase the probability of male partner involvement in choice of delivery site by 23.0% (p=0.002).
Table 4.15: Effect of change in the independent variables on probability of male partner involvement in choice of delivery site

Marginal effects after logit

\( y = \Pr (\text{male involvement}) \) (predict)

\[ = 0.39478003 \]

| Variable | \( \text{dy/dx} \) | \( z \) | \( P>|z| \) | (95% C.I.) | \( X \) |
|----------|------------------|-----|--------|---------|-----|
| Maeduc | 0.0694082 | 1.21 | 0.226 | -0.042846 | 0.181662 | 1.84541 |
| Womedu | 0.094079 | 1.53 | 0.125 | -0.026222 | 0.21438 | 1.66667 |
| Wonincom | -0.0004005 | -0.01 | 0.992 | -0.076221 | 0.07542 | 1.62802 |
| Malincom | 0.032508 | 1.24 | 0.216 | -0.018998 | 0.084014 | 3.14493 |
| Womknow* | 0.2320616 | 3.03 | 0.002 | 0.082135 | 0.381988 | 0.391304 |
| Wompercep* | 0.1028676 | 1.07 | 0.286 | -0.086043 | 0.291778 | 0.236715 |
| Menpercep* | 0.1352237 | 1.60 | 0.109 | -0.030301 | 0.300748 | 0.333333 |

(*) \( \text{dy/dx} \) is for discrete change of dummy variable from 0 to 1

**Key:** maedu=male education, womedu=women education, wonincom=women income, malincom=male income, womknow=women knowledge, wompercep=women perception, menpercep=male perception, OR=odds ratio, \( z = z \)-score for test, \( P>|z| = p \)-value for \( z \)-test, 95% C.I.=95% confidence interval, \( x = \) mean values
CHAPTER FIVE: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

5.1.1 Level of male partner involvement in choice of delivery site

Male involvement enables men to support their spouses to utilize emergency obstetric services early, adequately prepare for birth and ready themselves for complications. This can lead to a reduction in all the three phases of delay (that is delay in making decision to seek care, delay in accessing the care and delay in receiving the care) (Odimegwu et al., 2005). In addition, it has also been argued that reducing maternal deaths by 75% throughout the world by 2015 will take the involvement of men in countries where it matters most (USAID, 2010).

This study showed that although the male partners are key decision makers and financial providers, most decisions on delivery site and accessing the delivery site are made without their participation. This is consistent with results of studies by Nantamu (2011) done in Jinja Uganda and Van et al., (2006) in Western Kenya. In addition to the above studies, the findings also agree with studies by Dia (2005) in Senegal, Wanjira et al., (2011) in Kenya and Kabakyenga et al., (2014) in Uganda. However, it differs significantly with studies conducted in Kooki County in Uganda by Bua (2008), KDHS (2009) and in Ethiopia by Wassie et al., (2014). The differences could be attributed to narrow definition of male partner involvement in these other studies whereby they viewed male involvement as just making a joint decision on site of delivery unlike in this study where male partner involvement includes making a joint decision on the site of delivery and facilitating the woman to access the delivery site.
Low male partner involvement would be attributed to low knowledge of male partner involvement and benefits of involvement among the women and male partners. In addition, lack of programs that reach out for men, many men may not be aware why and how they need to be involved and what services are there for them and their partners, viewing delivery issues as women’s affair, a feeling of embarrassment by male partners when participating and culturally defined gender roles in many countries may hinder male participation (Waltson, 2005).

Low education level especially among women may make it difficult to comprehend health messages, follow them or even share them with the male partners. Some cultural beliefs and practices that hinder male partner involvement may exist though not openly acknowledged. Lack of involvement may contribute to the three phases of delay. Therefore there is a need to promote male partner involvement to reduce these delays and promote skilled birth attendance.

5.1.2 Socio-demographic and economic factors influencing male partner involvement in choice of delivery site

Age of both the women and male partners was not associated with male partner involvement. A male partner would be involved in choice of delivery site regardless of his or the woman’s age. This finding agrees with results of a study by Wassie et al., (2014), but differs with results of a study in Kinshasa Zaire by Ditekemena et al., (2012); who argued that there was higher male partner involvement where women were older than 25 years and findings of another study conducted in Western Kenya by Onyango et al., (2010) where the researchers argued that older men do not discuss
reproductive health issues. Although reasons for the differences for the earlier study could not be explained, for the later it could be due to a small sample size and among them 42% were health workers whom from their training and experience of dealing with patients have seen age as a factor influencing male involvement. This finding implies that to improve male partner involvement, women and male partner across age all groups should all be targeted.

In this study, women and male partner education influenced male partner involvement. These results are consistent with results of studies in India by Narang et al., (2013), in El Salvador by Carter (2005), in Nigeria by Iliyasu (2010), in Ghana by Esena et al., (2013) in Ethiopia by Paavilanen (2013) and in Uganda by Byamugisha et al., (2010). However, these results contrast results of a study in Ethiopia by Wassie et al., (2014) and in Zaire by Ditekemena et al., (2012). Probably because most participants in the study in Ethiopia were of grade 8 education level and had radios which was a constant source of information even for those with low educational level.

High education level enables them to do away with some of the cultural practices and beliefs that may hinder their involvement as argued by Nanjala et al., (2012). Additionally, educated women are likely to have good knowledge and awareness of health services, receptive of new health-related information and have better communication with husbands (Carter et al., 2005). To improve male partner involvement in choice of delivery site, there is need to improve the educational standards of the girls and boys and also women and their male partners taking advantage of the current free primary education and subsidized secondary education in Kenya.
Findings from this study indicated that high women and male partner income influenced male partner involvement. These findings are in agreement with those of a study in Ethiopia by Wassie et al., (2014). While some studies revealed that only high male partner income influenced male partner involvement (Reece et al., 2010 and Nanjala et al., 2012), another study reported that high women income influenced male partner involvement (Mpembeni et al., 2007). This difference may be due to the fact these studies involved either women or male partner only unlike in this study that involved both women and male partner. Male partners with high income are likely to be involved because they can afford to pay for costs (Wassie et al., 2014). Additionally, women with high income make wise decisions about their health (Mpembeni et al., 2007). It is also possible that women and male partners with high income are likely to have better education hence are more knowledgeable. There is a need to economically empower women and male partners to improve male partner involvement in choice of delivery site. Educating them on establishing and successfully running a business and making women enterprise fund available to women could possibly be a good beginning point.

Therefore in trying to improve male partner involvement in choice of delivery site, there is need to address these socio-demographic and economic factors alongside other factors.
5.1.3 Influence of the women and male partner knowledge and perception on male partner involvement in choice of delivery site

5.1.3.1 Influence of women and male partner knowledge on male partner involvement in choice of delivery site

Educating mothers and spouses to understand the complications of pregnancy and child birth leads to increased uptake of maternal and child health services (Mullany et al., 2006).

This study established that most of women (60.1%) and male partners (62.3%) had poor knowledge of male partner involvement in choice of delivery site and its benefits. These findings are consistent with findings of studies by Nanjala et al., (2012) and Mullany (2006). Low knowledge level among the respondents may be attributed to low education standards and poor or lack of programs with deliberate efforts to create awareness in the community on male partner involvement in child birth-related activities (Mullany, 2006).

This study established that poor women knowledge of male involvement and its benefits was a hindrance to male partner involvement. This result is consistent with those of a study by Mullany (2006) in Nepal and findings of a study done by Nanjala et al., (2012) in Busia, Kenya. Improving women knowledge of male partner involvement will result in increased male partner involvement in choice of delivery site. Therefore there is need to empower women with adequate and accurate knowledge on male partner involvement and its benefits to improve male partner involvement in not only choice of delivery site but also in other maternal and neonatal health.
5.1.3.2 Influence of the women and male partners’ perception on male partner involvement in choice of delivery site

Several studies have reported negative perceptions towards men attending ANC services. Frequently, men perceive that ANC services are designed and reserved for women, thus are embarrassed to find themselves in such “female” places (Byamugisha et al., 2010).

Consistent with poor knowledge, most women and their male partners in this study had poor perception of male partner involvement in selected RH-related activities. This finding is consistent with Nanjala et al., (2012). Poor perception could be due to the view that delivery is a natural phenomenon, fear of ridicule and lack of knowledge especially among men (Nanjala et al., 2012). Additionally, poor knowledge of male partner involvement and its benefits among the respondents may have contributed to poor perception as significant proportions of both women and male partners’ had poor knowledge (60.9% and 62.7%, respectively).

Poor perception of male partners involved in RH activities posed a challenge to male partner involvement. This is in tandem with a study by Mullany (2006) in a study in Nepal who argued that ridicule and teasing a male when trying to get involved might discourage him, with results by Nanjala et al., (2012) in Busia, Kenya whom in their study also argued that many men regarded delivery as a natural phenomenon and saw no need to be involved. Fear of being viewed as a jealous husband may make a man not to be involved in ANC (Nkuoh et al., 2010). As shown in a study in Asembo Kenya some men view male involvement in delivery issues as less important compared to striving to achieve economic wellbeing of the family (Kwambai et al., 2013).
Women perceiving child birth as a women affair that does not require male partner involvement may contribute to low male partner involvement as established by Onyango et al., (2010). (This can be viewed as some of the poor perceptions held by male partners).

Fear of being ridiculed by the community members, being branded some demeaning phrases may lead to poor perception (Onyango et al., 2010). These negative attributes were particularly expressed during FGD. A member of the FGD said “the husband’s family members see you as controlling the husband and so he listens to you more”. Such negative attributes will make many male partners to avoid being involved. Mullany (2006) in a study in Nepal also established that family members ridiculed and teased a male partner when trying to be involved in maternal health and were discouraged by this. Furthermore, several Nepali phrases or idioms had been coined for husbands who were viewed as ‘too’ supportive or involved with their wives.

Knowledge of male partner involvement in choice of delivery site, its benefits and perception of male involvement in RH activities have some influence in male partner involvement in choice of delivery site. There is need for practical and acceptable strategies to improve the knowledge and perception of men and women to improve male partner involvement.
5.1.4 Influence of women and male partner cultural beliefs and awareness of reproductive health policy on male partner involvement in choice of delivery site

5.1.4.1 Influence of women and male partner cultural beliefs on male partner involvement in choice of delivery site

The study revealed that an overwhelming majority of women and their male partners had no cultural beliefs against male partner involvement in choice of delivery site.

This suggests that many respondents were not keen to following negative cultural beliefs on reproductive health related issues because many tend to adversely affect maternal and neonatal health in addition to the health of the male partners themselves. This differs with Nanjala et al., (2012) who established that cultural beliefs of men lead to non-participation. This could be explained by the fact that the study by Nanjala et al.,(2012) was conducted in Busia which is more rural as opposed to this study which was done in an urban setting.

Few respondents having cultural beliefs that prohibited male partner involvement could be partly explained by the fact that most respondents were relatively young; the urban setting of the study area and the respondents might have not been aware of the cultural expectation concerning the role of male partners during pregnancy and childbirth. In addition, a significant proportion of the respondents had some education hence discarded negative cultural beliefs.

Most of the cultural beliefs given by the respondents were against male partner involvement in choice of delivery site. Viewing choice of delivery site as a women’s concern and a male partner feeling embarrassed in being involved should be discouraged. Although Nanjala et al., (2012) established in their study in Busia, Kenya that cultural beliefs of male partners contribute to non-participation of men in
pregnancy and child-birth, the influence of cultural beliefs on male partner involvement in this study was not established because very few had such beliefs. Further, some respondents did not state the cultural beliefs they had despite acknowledging having some cultural beliefs that were against male involvement in pregnancy and childbirth.

5.1.4.2 The influence of women and male partner awareness of reproductive health policy on male partner involvement in choice of delivery site

The Kenya National Reproductive Health Policy of 2007 is the first policy to recognise and emphasise the need for male involvement in reproductive health in Kenya. The policy recommends male involvement in family planning, pregnancy and childbirth, immunization among other services (GOK, 2007).

The findings of this study revealed that most of the respondents were not aware of any policy that promoted male partner involvement. Interestingly, even those respondents who said they knew the policy, they could not state it. This cast doubt whether they were actually aware of the policy. These findings dovetailed those of studies in Papua Guinea (Kura et al., 2013) and in Western Kenya (Onyango et al., 2010). Despite the Kenya National Reproductive Health Policy being in place 3 years prior to the later study, the respondents suggested that some policy be put in place to promote male involvement in reproductive health. This presents a clear case of lack awareness of existence of the policy. This implies that health policies supporting or promoting male involvement in reproductive health may not be reaching the targeted people (Kura et al., 2013). Again, low education levels and lack interest on the part of the respondents could explain why many of the respondents were not aware of these policies.
Although the influence of awareness of reproductive health policy on male partner involvement was not established in this study, a policy such as male partners accompanying the women to ANC is key to a successful pregnancy and childbirth. Couples get counselled and prepared to care for pregnancy, emergency preparedness and child-birth. This leads to early decision making and leading to improved maternal health. Every effort should therefore be made to disseminate the available policy(s) that have a potential for improving male partner involvement in maternal, child and neonatal health.

5.2 Conclusions

5.2.1 Level of male partner involvement in choice of delivery site

The findings showed that there is low male partner involvement in choice of delivery site among women delivering at Coast Level Five Hospital, Mombasa County. This calls for a need to initiate programs to promote male partner involvement in choice of delivery site and other reproductive health activities.

5.2.2 Women and male partner socio-demographic and economic characteristics influencing male partner involvement in choice of delivery site

The results revealed that women and male partners’ education and income influenced male partner involvement in choice of delivery site. This implies that there is a need to improve education and economic empowerment of women and male partners to improve male partner involvement in maternal, neonatal and child health.
5.2.3 Influence of women and male partner knowledge and perception on male partner involvement in choice of delivery site

Most participants in this study had poor knowledge of male partner involvement in choice of delivery site and poor perception of male partners involved in RH-related activities. This implies knowledge gaps that need to be addressed. Women knowledge and perception of the women and male partners influenced male partner involvement in choice of delivery site. The women should be empowered with accurate information on male partner involvement and its benefits. In addition, there is need to address the poor perception towards male involvement in RH activities by women and male partners to improve male partner involvement.

5.2.4 Influence of women and male partners’ cultural beliefs and awareness of reproductive health policy on male partner involvement in choice of delivery site

Few respondents’ had cultural beliefs that prohibited male partner involvement in RH activities and were aware of the reproductive health policy that promoted male partner involvement. Furthermore, most of those respondents who had these beliefs and those who were aware of the policy never stated the beliefs and the policy they were referring to. Because of these, it was difficult to precisely establish the influence of cultural beliefs and health policy awareness on male partner involvement in choice of delivery site. However, there is a gap in awareness of the RH policy that should be addressed.
5.3 Recommendations

Based on the study results, this study recommends that:

1. To increase male partner involvement, the management of Coast Level Five Hospital and Mombasa County government should come up with strategies and Programs that will promote male involvement in reproductive health.

2. The Mombasa County government should create awareness on the importance of improving education level taking advantage of the free primary education and subsidized secondary education. The government should also facilitate economic empowerment of women and male partners through facilitation of some credit facilities and trainings in basic business management for men and women to initiate income generating activities.

3. To improve knowledge on male involvement, its benefits and to improve perception towards male involvement in reproductive health, the health workers in Mombasa County should create awareness on male partner involvement and its benefits through mass media, health talks at ANC, community outreaches among other ways.

4. The Mombasa County government through the ministries of information and communication and ministry of health should disseminate the Kenya National Reproductive Health Policy that emphasises male involvement in RH. In addition, the county government should enact a policy that will compel all men to accompany their pregnant spouses to ANC. This policy should make it mandatory for all employers to give men with pregnant spouses time off to accompany them to ANC (like the paternal leave) to make it easier for their involvement.
5.4 Further research

Few studies have been conducted on male involvement in childbirth. Therefore this study recommends that:

1. A similar study should be expanded to check and compare findings across geographic regions, classes, and include those women delivering at home.

2. To conclusively establish the influence of cultural beliefs and reproductive health policy awareness on male partner involvement, further research should be undertaken.
REFERENCES


Bua John (2008): Barriers and Supportive Factors to Men's Participation in Perinatal Care in Kooki County Rakai district. *MPH dissertation presented to Makerere University School of Public Health.*


Kaye D. k., Kakaire O., Nakimuli A., Osinde M.O., Mbalinda S.N. & Kakande N. (2013): Male involvement during pregnancy and childbirth: men’s perceptions, practices and experiences during the care for women who developed childbirth complications in Mulago Hospital, Uganda; *Pregnancy and Childbirth; 10*:46


Michael Kani (2013): Mother’s social constructions of male involvement in maternity care in Chinsali district: A dissertation submitted to the University of Zambia in partial fulfilment of the requirements for the degree of masters in gender studies the University of Zambia.


Mullany, B. C., Becker, S., & Hindin, M. J. (2006). The Impact of including husbands in antenatal health education services on maternal health practices in urban


Naomi Walston (2005): Challenges and Opportunities for Male Involvement in Reproductive Health in Cambodia. Policy Project/Cambodia


Reuben, K. Esena, Mary-Margaret Sappor (2013): Factors associated with the utilization of skilled delivery services in the Ga East Municipality of Ghana


APPENDICES

Appendix 1: A map of Mombasa
Appendix 2: Questionnaire - English

PART 1: WOMEN RESPONDENTS

SECTION A: SOCIO-DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS

(Please tick against the respondent's choice)

Qn.1 How old were you at your last birth day?
   a) below 20   b) 21-25   c) 26-30   d) 31-35   e) 36-40   g) above 40

Qn.2 What is your highest level of education?
   a) none   b) primary   d) secondary   e) college (certificate)
   d) college (diploma)   f) university

Qn.3 Which is your religion?
   a) Muslim   b) catholic   c) protestant   d) Africa traditional religion
   e) None   f) others (specify).................................

Qn.4 What is your male partner’s religion? (if different)
   a) Muslim   b) catholic   c) protestant   d) Africa traditional religion
   e) None   f) others (specify).................................

Qn.5 What is your ethnic group? ................................................

Qn.6 What is your male partner’s ethnic group? ……………………..

Qn.7 What is your marriage relationship?
   a) monogamous   b) polygamous

Qn.8 In which district do you reside?
   a) Likoni   b) Kisauni   c) Kilindini   d) Mombasa   e) others (specify)………

Qn.9 How much income do you get per month (in kshs)?
   a) Below 5,000   b) 5,001-10,000   c) 10,001-15,000
   d) 15,001-20,000   e) 20001-25,000   f) above 25,000

Qn.10 Do you and your male partner drink alcohol?
   a) Yes (both drink)   b) husband only   c) wife only   d) none drinks

SECTION B: LEVEL OF MALE INVOLVEMENT

Qn.11 How many deliveries have you had in your lifetime?
   a) 1-2   b) 3-4   c) more than 4

Qn.12 Where did you deliver in your previous pregnancy?
   a) At home   b) private clinic   c) public dispensary/health centre
d) public hospital  e) private hospital

**Qn.13** Who decided that you deliver in this hospital during this latest Pregnancy?
   a) Self alone  
   b) her partner alone  
   c) self and partner jointly  
   d) mother in-law  
   e) health workers at ANC clinic  
   g) others (specify)----------

**Qn.14** Did you discuss and choose with your husband where to deliver?
   a) yes  
   b) no  

*If no, why?* ____________________________________________________________

Qn.15 Did your male partner provide the support to access the delivery site?

   a) Yes  
   b) no

**SECTION C: KNOWLEDGE AND PERCEPTION**

**Qn.16** What is your understanding of male partner involvement in choice of delivery Site?
__________________________________________________________

**Qn.17** Are you aware of the need for male partner involvement in choice of delivery site?
   a) yes  
   b) no

**Qn.18** In your opinion is it necessary to involve male partners in choice of delivery Site?
   a) yes  
   b) no

Give reasons for your response
__________________________________________________________

**Qn.19** Where did you get the information about male involvement from?
   a) Fellow pregnant women  
   b) health workers at ANC  
   c) mass media (Radio, TV, Newspapers)  
   d) Book and journals  
   e) others (specify) ---------------

**Qn.20** Please indicate the number that best describes your perception on male Involvement in the activities stated below.

   **Key**: 1=strongly disagree  
   2=disagree  
   3=undecided  
   4=agree  
   5 =strongly agree

   a) Men partners should accompany spouses during ANC visits
b) Male partners should participate in discussing maternal health issues
c) Male partners should participate in choosing the delivery site
d) Male partners should escort their spouses to the chosen delivery site

SECTION D: CULTURAL BELIEFS AND REPRODUCTIVE HEALTH POLICY AWARENESS

Qn.21 When you have health problems whom do you share with first?
a) My wife   b) relatives(brother, sister or parents)   c) friends
d) others(specify)__________________
(Please write clearly in capital letters)

Qn.22 Do you have any cultural beliefs about male partner participation in choice of delivery site?
a) yes   b) no
If yes, state these beliefs

Qn.23 Did you attend any ANC visit during the latest pregnancy?
a) yes   b) no

Qn.24 If you attended any ANC visit, have you ever been accompanied by your male partner to attend any ANC visit?
a) yes   b) no
If no, why

If yes answer QN.25, If No skip it

Qn.25 In your opinion do health facilities support male partners who accompany their spouse to ANC visits?
a) yes   b) no
Please briefly explain your response

Qn.26 Are you aware of any reproductive health policy or rule that support male
Partner involvement in choice of delivery site?
   a) yes          b) no

*If yes*, state it

____________________________________________________________________

Thank you for your cooperation and response

PART 2: MALE PARTNER RESPONDENTS

SECTION A: SOCIO-DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS

*(Please tick against the respondent's choice)*

Qn.1 How old were you at your last birth day?
   a) below 20   b) 21-25   c) 26-30
   d) 31-35   e) 36-40   g) above 40

Qn.2 What is your highest level of education?
   a) none   b) primary   c) secondary
   d) college (certificate)   e) college (diploma)   f) university

Qn.3 How much income do you get per month (in kshs)?
   a) below 5,000   b) 5,001-10,000   c) 10,001-15,000
   d) 15,001-20,000   e) 20,001-25,000   f) above 25,000

SECTION B: LEVEL OF MALE INVOLVEMENT

Qn.4 Who decided that your spouse delivers here (Coast Level Five) during the latest pregnancy?
   a) herself alone   b) myself alone   c) myself and her jointly
   d) mother in-law   e) health workers at ANC clinic   g) others (specify)---------------

Qn.5 Did you discuss and choose with your spouse where to deliver?
   a) yes   b) no

*If no*, why?

____________________________________________________________________

Qn.6 Did you provide her the support to access the chosen delivery site?

   a) Yes   b) no
SECTION C : KNOWLEDGE AND PERCEPTION

Qn. 7 What is your understanding of male partner involvement in choice of delivery Site?
_____________________________________________________________________
_____________________________________________________________________

Qn.8 Are you aware of the need for male partner participation in choice of delivery Site and other maternal health issues?
  a) yes       b) no

Qn.9 In your opinion, is it necessary to involve male partners in choice of delivery site?
  a) yes       b) no

Give a reason for your response
_____________________________________________________________________
_____________________________________________________________________

Qn.10 Where did you get the information about male involvement from?
  a) Fellow men  b) from wife   c) mass media (Radio, TV, Newspapers)
  d) Book and journals   e) from health workers at ANC  f) others (specify)--------

Qn.11 Please indicate the number that best describes your perception on male Involvement in the activities stated below.

Key  1=strongly disagree 2=disagree 3=neutral 4=agree 5=strongly agree
  a) Men should accompany spouses to ANC
  b) Male partners should participate in discussing maternal health issues
  c) Male partners should participate in choosing the delivery site
  d) Male partners should escort their spouses to the chosen delivery site

SECTION D : CULTURAL BELIEFS AND REPRODUCTIVE HEALTH POLICY AWARENESS

Qn.12 When you have health problems whom do you share with first?
  a) My wife   b) relatives (brother, sister or parents)   c) friends
  d) others(specify)_______________________

(Please write clearly in capital letters)

Qn.13 Do you have any cultural beliefs about male partner involvement in choice of delivery site?
  a) yes       b) no
If yes, state these beliefs

Qn.14 Did your spouse attend any ANC visit during the current pregnancy?
a) yes   b) no

Qn.15 Are you aware of any reproductive health policy that support male involvement Choice of delivery site?
a) Yes  b) no
   if yes, state it

Thank you for your cooperation and response

Appendix 3: Questionnaire -Kiswahili version

Nambari ---------------

SEHEMUYA 1: WASHIRIKI WA KIKE
KIPENGELE A: UTAMBULISHO WA WASHIRIKI

(Tafadhali weka tiki kwa jibu la mshiriki).

Swali.1 Ulikuwa na umri gani katika sherehe yako ya mwisho ya kuzaliwa? (kwa miaka)
   a) Jini ya 20   b) 20-25   c) 26-30   d) 31-35   e) 36-40   f) Zaidi ya 40

Swali.2 Elimu yako ya juu kabisa ni gani?
   a) Hakuna elimu yoyote   b) Shule ya msingi   c) Sekondari   d) chuo (cheti)
   d) Chuo (diploma)   f) Chuo kikuu

Swali.3 Dini yako ni gani
   a) Islamu   b) Katoliki   c) Protestantti   d) Dini asili ya kiafrika
   e) Sina dini yoyote   f) Zinginezo (itaje)

Swali.4 Dini ya mwenzako wa kiume ni gani? (kama ni tofauti)
   a) Islamu   b) Katoliki   c) Protestantti   d) Dini asili ya kiafrika
   e) Hana dini yoyote   f) zinginezo (taja)

Swali.5 Kabila yako ni gani?

Swali.6 Kabila ya mwenzako wa kiume ni gani?

Swali.7 Mko bibi wangapi?
   a) Mmoja   b) Zaidi ya mmoja

Swali.8 unakaa/unaishi katika wilaya gani?
   a) Likoni   b) Kisauni   c) Kilindini   d) Mombasa   e) Zinginezo

Swali.9 Je unapata mapato au pesa kiasi gani Kwa mwezi? (sh.k)
   a) Jini ya 5,000   b) 5,001-10,000   c) 10,001-15,000
   d) 15,001-20,000   e) 20001-25,000   f) Zaidi ya 25,000

Swali.10 Je wewe na mwenzako wa kiume mnakunywa tembo?
   a) Ndio (zote)   b) Mwenzangu wa kiume au bwana pekee   c) Mimi pekee
   d) Hakuna yoyote

KIPENGELE B: KIWANGO CHA KUHUSIKA KWA WANAUME.

Swali.11 Umejifungua mara ngapi maishani mwako?
   a) 1-2   b) 3-4   c) Zaidi ya mara 4

Swali.12 Je ulijifungua wapi katika mimba ya hapo awali?
   a) Nyumbani   b) Kliniki ya kibinafsi   c) Zahanati/kituo cha afya cha Uma
   d) Hospitali ya Uma   e) Hospitali ya kibinafsi   f) Hii ni mara ya kwanza.

Swali.13 Nani aliamua ujifungulie kwa hii hospitali kwa mimba hii ya sasa?
Swali.14 Je uliwahe jadiliana na kuamua na mumeo mahali pa kujifungua?

a) Ndio b) La

*Kama la,* kwa nini?

_________________________________________________________

Swali.15 Je mume wako alikusaidia kufika mahali pa kujifungua?

a) Ndio b) La

**KIPENGELE C: UFAHAMU NA HISIA**

Swali.16 Kulingani na wewe, ni nini maana ya kuhusika kwa wanaume kuamua mahali pa Kujifungua?

_________________________________________________________

Swali.17 Unafahamu kama wanaume wanastahili kuhuzishwa kuamua mahali pa kijifungulia?

a) Ndio b) La

Swali.18 Kwa maoni yako, ni muhimu wanaume kuhusika kumua mahali pa kujifungua?

a) Ndio b) La

Toa sababu ya jibu lako

_________________________________________________________

Swali.19 Ulifahamu kutoka wapi kuwa wanaume wastahili kuhusika?

a) Wanawake wenzangu wachawazito b) Wahudumu wa afya kwa kliniki cha wachawazito
c) Vyombo vya habari kama radio, TV na magazeti, ) d) Vitabu na majorida
e) Zinginezo (taja)-

Swali.20 Tafadhali jaza nambari ya maelezo ambayo yanaeleza kikamilifu hisia mshiriki kuhusu wanaume kuhusika katika maswala yafuatayo.

(muhimu : chagua jibu kutoka kwa maelezo yafuatayo na kila swala lahitaji kujibiwa)

1=kataa kabisa 2=kataa 3=hakuna hisia 4=kubali 5=kubali kabisa

a) Wanaume wanastahili kuandamana na bibi wakati wa kuenda wa kliniki_
b) Wanaume kushiriki kujadiliana kuhusu maswala ya afya ya akina mama_
c) Wanaume kushiriki kuchagua mahali pa kujifungua_
d) Wanaume wanastahili kusindikiza wake hadi mahali pa kujifungua_
KIPENGELE D: UTAMADUNI NA SERA ZA AFYA

Swali.21 Ukiwa na shida ya kiafya, ni nani unambulisha kwanza?
   a) mwenzangu wa kiume  b) jamii (ndugu, dada, au wakati)  c) marafiki
d) wengine (taja)________________

(Tafadhali andika kwa herufi kubwa)

Swali.22 Je unamini mila au itikadi zozote za kitamaduni kuhusu wanaume kuhusika Kuamua mahali pa kujifungua?
   a) Ndio           b) La
   
   kama ndio , taja hizi mila

__________________________

Swali.23 Je uliwahi kuenda kliniki cha wachawazito kwa mimba ya sasa?
   a) Ndio       b) La

Swali.24 Kama alienda, umewahi kuandamana naye kuenda kliniki cha Wachawazito siku yoyote?
   a) Ndio       b) La

Kama ni la, kwa nini?

__________________________

Kama ni ndio, Jibu swali la 25 Kama la liache swali hilo

Swali.25 Kwa maoni yako, vituo vya afya vinaunga mkono wanaume wanaoandamana na wake Kuenda kliniki ya wachawazito?
   a) Ndio       b) La
   kwa kifupi fafanua jibu lako

__________________________

Swali. 26 Je unafahamu sera yoyote ya afya ya uzazi ambayo inaunga wanaume Kushiriki kuamua mahali pa kujifungua?
   a) Ndio       b) La
Kama ndio, taja hiyo sheria

Asante kwa ushirikiano wako na kujibu.

SEHEMU YA 2. WASHIRIKI WA KIUME

KIPENGELE A: UTAMBULISHO WA WASHIRIKI
(Tafadhali weka tiki kwa jibu la mshiriki).

Swali.1 Ulikuwa na umri gani katika sherehe yako ya mwisho ya kuzaliwa? (kwa miaka)

a) Jini ya 20 b) 20-25 c) 26-30 d) 31-35 e) 36-40 f) Zaidi ya 40

Swali.2 Elimu yako ya juu kabisa ni gani?

a) Hakuna elimu yoyote b) Shule ya msingi c) Sekondari d) Chuo (cheti) e) Chuo (diploma) f) Chuo kikuu

Swali.3 Je unapata mapato au pesa kiasi gani Kwa mwezi? (sh.k)

a) Jini ya 5,000 b) 5,001-10,000 c) 10,001-15,000 d) 15,001-20,000 e) 20,001-25,000 f) Zaidi ya 25,000

KIPENGELE B. KIWANGO CHA WANAUME KUHUSIKA

Swali.4 Nani aliamua mwenzako aji fungulie kwa hii hospitali (Coast Level Five) kwa mimba hii ya sasa?

a) Yeye pekee b) Mimi pekee c) Mimi na yeye kwa pamoya d) Mama mkwe e) wahudumu wa afya kwa kliniki cha wachawazito g) Wengine (taja) -------

Swali.5 Je uliwaahi jadiliana na kuamua na mkeo/bibi mahali pa kujifungua?

a) Ndio b) La

Kama la, kwa nini?

Swali.6 Je ulimsaidia mkeo/bibi yako kufika mahali pa kujifungua?

a) Ndio b) La
**KIPENGELE C: UFAHAMU NA HISIA**

**Swali.7** Kulingani na wewe, ni nini maana ya kuhusika kwa wanaume kuamua mahali pa Kujifungua?

**Swali.8** Je unafahamu kama wanaume wanastahili kuhusishwa kuamua mahali pa Kijifungulia?
   a) Ndio       b) La

**Swali.9** Kwa maoni yako, ni muhimu wanaume kuhusika kumua mahali pa kujifungua?
   a) Ndio       b) La
   Toa sababu kwa jibu lako

**Swali.10** Je Ulifahamu kutoka wapi kuwa wanaume wastahili kuhusika?
   a) Wanaume wenzangu  b) kwa mke c) Vyombo vya habari kama radio, TV na magazeti, )
   d) Vitabu na majarida  e) Wahudumu wa afya kwa kliniki cha wachawazito
   f) Zinginezo (taja)---------------------

**Swali.11** Tafadhali jaza nambari ya maelezo ambayo yanaelifereka hisia mshiriki Kuhusu wanaume kuhusika katika maswala ya kujifungua.

(Muhimu: chagua jibu kutoka kwa maelezo yafuatayo na kila swala lahitaji kujibiwa)

**Kielelezo**
1= Nakataa kabisa  2= Nakataa  3= Hakuna hisia  4= Nakubali  5 = Nakubali kabisa
   a) Wanaume wanastahili kuandaman na bibi wakati wa kuenda wa kliniki_
   b) Wanaume kushiriki kujadiliana kuhusu maswala ya afya ya akina mama_
   c) Wanaume kushiriki kuchagua mahali pa kujifungua_
   d) Wanaume wanastahili kusindikiza wake hadi mahali pa kujifungua_

**KIPENGELE D: UTAMADUNI NA SERA ZA AFYA**

**Swali.12** Ukiwa na shida ya ki afya, ni nani unamjulisha kwanza?
   a) mke au bibi  b) jamii (ndugu, dada, au wakati)  c) marafiki
   d) wengine( taja)_-------------------

(Tafadhali andika kwa herufi kubwa)

**Swali.13** Je una mila au itikadi zozote za kitamaduni kuhusu wanaume kuhusika kuamua Mahali Pa kujifungua?
   a) Ndio       b) La
   kama ndio, taja hizo mila
Swali. 14 Je unafahamu sera yoyote ya afya ya uzazi ambayo inaunga wanaume kushiriki Kuchagua mahali pa kujifunga?

a) Ndio  b) La

*Kama ndio*, taja hiyo sheria

Asante kwa ushirikiano wako na kujibu.

Appendix 4: Focus group discussion guide for women

Title: Male partner Involvement in choice of delivery site among women

Delivering at Coast Level Five hospital, Mombasa County
Introduction – Welcome
Introduction of moderators

Objectives of the focus group
We are going to talk about topics related to choice of delivery site. The purpose of this discussion is for you to share your ideas and experiences with us so that we can understand your views that will help in improving male involvement in choice of delivery as one of the ways of improving skilled birth attendance. Improved skilled birth attendance will contribute to reducing maternal mortality due to delivery-related complications.

Participation
There is no right or wrong answers to the questions that we will be asking you. Please feel free to answer exactly as you feel. Anything you say here will be kept confidential. We will never mention your name outside this room. If you do not wish to answer any particular question, that is okay. If you need to leave at any time that is fine. I request you to allow us tape the proceedings/ note taking of this meeting so that to capture all the issues as you express them.

Discussion questions guide.

Qn.1 Do you involve your male partners when choosing the delivery site?
Probes). Explain your response (how?). Is it important/ necessary? Explain your response briefly
Qn.2 What do you understand by male partner involvement in choice of delivery site?
Qn.3 Are you aware of the need for male partner involvement choice of delivery site?
Qn. 4 How do you perceive male partners who participate in choice of delivery site?
Probe) what about other people in your community?
Qn.5 Have you ever been accompanied by your male partner for ANC visit?
Briefly explain your response.
Qn.6 In your opinion, why could some male partners participate in choosing a delivery site
while others do not?

Probes).

Any cultural issues, information gap, or health policy issues?

Thank you very much for your time and information
Do you have any questions or comments on the above issues we have been discussing?
(Answer any questions raised and thank the participants before closure of the session.

Appendix 5: Focus group discussion guide for male partners
Title: Male partner Involvement in choice of delivery site among women delivering at Coast Level Five hospital, Mombasa County
Introduction

We are going to talk about topics related to choice of delivery site. The purpose of this discussion is for you to share your ideas and experiences with us so that we can understand your views that will help in improving male involvement in choice of delivery as one of the ways of improving skilled birth attendance. Improved skilled birth attendance will contribute to reducing maternal mortality due to delivery-related complications.

Participation

There is no right or wrong answers to the questions that we will be asking you. Please feel free to answer exactly as you feel. Anything you say here will be kept confidential. We will never mention your name outside this room. If you do not want to answer particular any question, that is okay. If you need to leave at any time that is fine. I request you to allow us tape the proceedings /note taking of this meeting so that to capture all the issues as you express them.

Discussion questions guide

Qn.1 Have you ever been involved by your spouses in choosing the delivery site?
Probes). Explain your response (how?). Is it important/necessary? Explain your response briefly
Qn.2 What do you understand by male partner involvement in choice of delivery site?
Qn.3 Are you aware of the need for male partner involvement choice of delivery site?
Qn.4 How do you perceive male partners who participate in choice of delivery site?
Probe) what about other people in your community?
Qn.5 Have you ever accompanied your spouse for ANC visit?
Give reasons for your response
Qn.6 In your opinion why could some male partners participate in choosing a delivery site while others do not?
Probes).
Any cultural issues, information gap or health policies?

Thank you very much for your time and information
Do you have any questions or comments on the above issues we have been discussing?
(Answer any questions raised and thank the participants before closure of the session

Appendix 6: Focused group discussion – Kiswahili version

Mwongozo wa mjadala
Kichwa: Kuhusishwa Kwa wanaume katika kuchagua mahali pa kujifungua miongoni mwa wanawake wanaojifungua katika hospital ya pwani ya kiwango cha tano, kounti ya Mombasa
Mahali pa mjadala……………………………………
Tarehe ya mjadala……………………………………
Idadi ya waliowutia mjadala………………………
Jina la mwenyekiti…………………………………….
Jina la mzaidizi…………………………………….

-Kujitambulishia.
-Kujitambulishia kwa mtafiti.
Madhumuni ya mjadala
Mjadala huu ni wa kuzungumuzia swala la wanaume kuhuzishwa katika kuamua mahali pa bibi kujifungua. Mathumuni ya mjadala ni kuweza kubadilishana maoni hili kulewewa hili swala Kwa undani. Maoni yenu yatazaidia kutafuta njia za kuimarisha kuhuzishwa kwa wanaume zaidi hili kuimarisha afya na maisha ya akina mama wajawazito. Hii itasaidia kuongeza idadi ya wanawake wanaojifungua hospitalini na kupunguza visa vya akina mama kufa wakati wa kujifungua.

Kushiriki
hakuna jibu sahii au sio sahii kwa maswali ya mjadala. Kila mtu ajisikie huru na kutoa maoni yake na kushiriki kwa mjadal bila hofu au wasiwasi wowote.

Kijitambulisha (jina moja, umri, mahali unakaa)

Maswali ya mjadala
Swali.1. Je mnahusisha wanaume au mabwana katika kuamua mahali pa kujifungua?
Fafanua jawabu au jibu lako (kivipi?). Je ni muhimu kwahuzisha?

Swali la 2. Kwa maoni yenu, ni nini maana ya kuhuzisha wanaume katika kuamua mahali pa kjifungua?

Swali la 3. Je mnafafahamu kwamba wanaume wanastahili kuhuzishwa kuamua mahali pa wanawake kjifungua?
- Ulijulia wapi?

Swali la 4. Je nyinyi mwawaonaje au mnaajulikiaje wanaume au mabwana ambao wanaoshiriki kuamua mahali pa wanawake au mabibi kjifungua?
- Watu wengine pale mnaajulikiaje hawa wanaume?

Swali la 5. Je mumewahi kuenda kliniki za wanawake wachawazito nkiandamana na wanaume wenu?
- Fafanua jibu lako kwa ufupi

Swali la 6. Kwa maoni yenu, Ni Kwa nini wanaume wengine hawashiriki katika kuamua mahali pa mabibi kjifungua?
- Maswala ya mila na utamaduni?
- Swala la kutofahamu umuhimu wake?
- Sheria Fulani katika za afya?

Nawashukuru yote kwa muda wenu na maoni yenu
Je kuna swali lolote au jambo la ziada la kujangia kuhusu mjadala wa leo?
(Kujibu maswali na kushukuru wote tena na kutamatisha mjadala)
Appendix 7: KU Graduate School Authorization

KENYATTA UNIVERSITY
GRADUATE SCHOOL

Email: dean-graduate@kunyata.KE
Website: www.kunyata.KE

P.O. Box 43844, 00100
NAIROBI, KENYA
Tel. 871000/1 Ext. 57530

Date: 17th September, 2013

The Permanent Secretary,
Ministry of Higher Education, Science & Technology,
P.O. Box 30040,
NAIROBI

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION ONCHONGA JAMES MAINA – REG. NO. Q37/20350/2012

I write to introduce Mr. Onchonga’s James Maina who is a Postgraduate Student of this University. He is registered for M.P.H degree programme in the Department Community Health.

Mr. Onchonga’s James Maina intends to conduct research for a M.P.H proposal entitled “Male Farmer Involvement in Choice of Delivery Site among Women Delivering at FH Coast, Mombasa County.”

Any assistance given will be highly appreciated.

Yours faithfully,

(Signed)

FOR: MRS. LUCY N. MBABBU
FOR: DEAN, GRADUATE SCHOOL

(Seal)
Appendix 8: KU ERC Ethical Clearance

KENYATTA UNIVERSITY
ETHICS REVIEW COMMITTEE

Fax: 8711242/8711575
Email: kuerc.chairman@kuc.ac.ke
kuerc.secretary@kuc.ac.ke
Website: www.kuc.ac.ke

P. O. Box 43844
Nairobi, 00100
Tel: 8710901/12
Tel: 8710901/12

Our Ref: KU/R/COMM/51/261

Date: 29th November, 2013

James Maina Onchong’a,
Department of Community Health,
Kenya University,
P.O. Box 43844 00100-Nairobi

Dear Mr. Onchong’a,

APPLICATION NUMBER PKU/165/1 145 – "MALE PARTNER INVOLVEMENT IN CHOICE OF DELIVERY SITE AMONG WOMEN DELIVERING AT PGH COAST, MOMBASA" - Version 2

1. IDENTIFICATION OF PROTOCOL
   The application before the committee is with a research topic “Male partner involvement in choice of delivery site among women delivering at PGH Coast, Mombasa" dated 28th November, 2013.

2. DECISION
   The committee has considered the research protocol in accordance with the Kenya University Research Policy (section 7.2.1.3) and the Kenya University Ethics Review Committee Guidelines AND APPROVED that the research may proceed for a period of ONE year from 29th November, 2013.

3. ADVICE/CONDITIONS
   i. Progress reports are submitted to the KU-ERC every six months and a full report is submitted at the end of the study.
   ii. Serious and unexpected adverse events related to the conduct of the study are reported to this board immediately they occur.
   iii. Notify the Kenya University Ethics Committee of any amendments to the protocol.
   iv. Submit an electronic copy of the protocol to KUERC.

When replying, kindly quote the application number above

PROF. NICHOLAS K. GIKONYO
CHAIRMAN ETHICS REVIEW COMMITTEE

[Signature]

Accept the advice given and will fulfill the conditions therein.

Signature: [Signature]  Dated this day of [Date] 2013.

cc. Vice-Chancellor
Director: Institute for Research Science and Technology
Appendix 9: NACOSTI Research Permit

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471, 2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

Ref: No.

NACOSTI/P/14/5860/640

James Maima Onchonga
Kenyatta University
P.O.Box 43844-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on “Male partner involvement in choice of delivery site among women delivering at PGH coast, Mombasa County, Kenya,” I am pleased to inform you that you have been authorized to undertake research in Mombasa County for a period ending 31st May, 2014.

You are advised to report to the Medical Superintendent, Provincial General Hospital, Mombasa County before embarking on the research project.

On completion of the research, you are expected to submit two hard copies and one soft copy in pdf of the research report/thesis to our office.

Said Hussein
FOR: SECRETARY/CEO
NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

Copy to:

The Medical Superintendent
Provincial General Hospital.
Appendix 10: Coast Level Five Hospital – ERC Approval

MINISTRY OF HEALTH

Telegram: “MEDICAL”, Mombasa
Phone: Mombasa 2141202/3, 222148, 222845
Fax: 2220101 E-mail: casadmin@cpgh.co.ke

To: Mr. Onchonga,
Department of Community Health,

C.C.
Chairman, ERC
Chief Administrator, CPGH
Director of Nursing
Nurse in Charge, Labour Ward

Ref. No. P/NO. 2011017230
Date: 16th February, 2014

This is to inform you that the CPGH Ethics & Research Committee has reviewed and approved your above proposal. The approval period is 16th February 2014 to 16th February, 2015.

This approval is subject to compliance with the following requirements:

a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.

b) All changes (amendments, deviations, violations etc) are submitted for review and approval by CPGH-ERC before implementation.

c) Death or life-threatening problems and severe adverse events (SAE5) or unexpected adverse events whether related or unrelated to the study must be reported to the CPGH-ERC within 72 hours of notification.

d) Any changes, anticipated or otherwise that may increase the risk or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to CPGH-ERC within 72 hours.

e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period (attach a comprehensive progress report to support the renewal).

f) Clearance for export of biological specimens must be obtained from CPGH-ERC for each batch of shipment.

g) Submission of an executive summary report within 90 days upon completion of the study. This information will form part of the database that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/or plagiarism.

DR. B. ATHMAN
SECRETARY, CPGH-ERC
Appendix 11: Consent form-English

My name is James Maina Onchonga. I am a Masters student from Kenyatta University. I am conducting a study on “Male Partner Involvement in choice of Delivery Site among Women Delivering at Coast Level Five Hospital, Mombasa County”. The information will be used by the Ministry of Medical Services to improve access and quality of Maternal Health in this hospital as well as in other regions of Kenya.

Procedures to be followed

Participation in this study will require that I ask you some questions in order to establish Male partner involvement. I will record the information from you in a questionnaire and also tape record for focus group discussion.

You have the right to refuse participation in this study. You will get the same care and medical treatment whether you agree to join the study or not and your decision will not change the care you will receive from the clinic today or that you will get from any other clinic at any other time.

Please remember that participation in the study is voluntary. You may ask questions related to the study at any time.

You may refuse to respond to any questions and you may stop an interview at any time. You may also stop being in the study at any time without any consequences to the services you receive from this clinic or any other organization now or in the future.

Discomforts and risks

Some of the questions you will be asked are on intimate subject and may be embarrassing or make you uncomfortable. If this happens, you may refuse to answer these questions if you so choose. You may also stop the interview at any time. The interview will take approximately ten minutes. However for focus group discussion it will take close to 2 hours.

Benefits

If you participate in this study you will help us to learn how to improve male partner involvement and hence improve maternal health.

Reward

If you agree to participate in this study, snacks will be provided and transport expenses will be reimbursed.
Confidentiality
The interviews and discussions will be conducted in a private setting within the hospital. Your name will not be recorded on the questionnaire and during Tape Recording. The questionnaires will be kept in a locked cabinet for safe keeping. Everything will be kept private.

Contact information
If you have any questions you may contact Dr. Tom Were on 0720 326 127 or Dr. Justus Osero on 0724 869 330 or the Kenyatta University Ethical Review Committee Secretariat on kuerc@ku.ac.ke.

Participant’s Statement
The above information regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand that my records will be kept private and that I can leave the study at any time. I understand that I will still get the same care and medical treatment whether I decide to leave the study or not and my decision will not change the care I will receive from the clinic today or that I will get from any other clinic at any other time.

Name of Participant……………………………………………………………………………………………

_________________________________________________________

Signature or Thumbprint Date

Investigator’s statement
I, the undersigned, have explained to the volunteer in a language s/he understands the procedures to be followed in the study and the risks and benefits involved.

Name of Interviewer……………………………………

___________________________ Date___________________________
Appendix 12: Consent form- Kiswahili

Jina langu ni James Maina Onchong’a mwanafunzi katika Chuo Kikuu cha Kenyatta. Ninafanya utafiti kuhusu “Kuhusika Kwa Wanaume kuchagua mahali pa kujifungu miongoni mwa Wanawake wanaojifungu katika hospitali ya pwani ya kiwango cha tano, Kaunti ya Mombasa”

M pangilio wa kufuatwa
Kushiriki kwa huu utafiti utahitaji kuulizwa maswali ambayo majibu nitajaza kwa fomu ya maswali au kunakili/kurekodi.
Uko na haki ya kutoshiriki kwa huu utafiti. Utapata huduma sawa hata kama utakubali au kukataa kushiriki. Uamuzi wako wakati uwekeza kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa hospitali hii wakati huu na ile ungepokea kwa 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Nambari ya mawasiliano
Ikiwa una swali lolote wasiliana na Dr. Tom Were kwa 0720 326 127 au Dr. Justus Osero kwa 0724 869 330 ama Chuo Kikuu cha Kenyatta Kamati ya maadili na kuthakimini utafiti kwa kuerc@ku.ac.ke.

Stetimento ya Mhojiwa

Jina la Mhojiwa/Mshiriki..............................................................

________________________________________________________________________

Sahihi/Kidole gumba Tarehe

Stetimento ya Mhoji
Mimi nimemweleza mshiriki kwa lugha ambayo anaelewa mpangilio utakaofuatwa katika huu utafiti na hatari na manufaa yanayohusika

Jina la Mhoji..............................................................

________________________________________________________________________

Sahihi Tarehe