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Male Involvement in Birth Preparedness through Health Facility Community Dialogue in Kajiado County- Kenya

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Abstract

Birth preparedness enhances readiness to handle pregnancy complications and probable delays experienced in seeking obstetric care. Male partners in the society are key influencers of maternal health outcome due to their financial power and cultural endowment that male figures command in the society hence impact on birth preparedness. In Kenya, there is limited data on male involvement in birth preparedness through health facility community dialogue. The study thematic area explored the influence of male partner factors on birth preparedness through health facility community dialogue in Kajiado County- Kenya. The study employed explorative-descriptive qualitative research design. The target population was households with male partners/spouses, married men who had children aged 0-2 years, aged 18 years and above. The study concluded that male partner perception, level of education, age at marriage, communication among partners and economic status had negatively influenced male partner involvement in birth preparedness. The study recommended that the County Government of Kajiado to come up with community engagement forums to dialogue with the community on birth preparedness through open maternity day forums and change the male perception on birth preparedness. The study also recommended that the Ministry of Education to empower the boy child by retention in school, the way it has system in place to track the status of the girl child in school for nomadic communities, this will avert early school dropout that leads to early marriages and high index of poverty levels. Finally, the male partners should foster communication between spouses to improve on pregnancy outcome.

Keywords: *Male Involvement, Birth Preparedness, Health Facility Community Dialogue*

1.0 Introduction

One of the key strategies to ensuring safety of a pregnant mother with her unborn baby is through having a birth preparedness plan that is individualized. WHO, (43) introduced a strategy of birth preparedness that is individualized in the antenatal care (ANC) model. This involves preconception care/ counselling, danger signs recognition, planning for skilled birthing, identification of a

preferred health care facility for delivery or obstetric emergencies, plans for transport means, funds set aside for emergency, plan for a care taker of the house while the woman goes to deliver, identification of a woman preferred birth companion during labour, identification of a potential blood donor and decision maker in case of emergency and involvement of the community in supporting pregnant mothers by educating communities on maternal health and ways to support pregnant mothers in-case of emergency. The male partner need to be involved in individualized birth plan at an early stage for it to succeed.

The Kenyan government has added the Linda mama package in birth preparedness where all pregnant mothers have to enroll with NHIF in order for them to benefit from free maternal care services (FMC) (28). All pregnant mothers are required to do an obstetric ultra-sound before delivery which is not covered under Linda Mama package. Also to improve on maternal indicators like ANC attendance especially the 4th ANC attendance which stands at 52% nationally according to KHIS, skilled birth at 62% as per KDHS, PNC, family planning at 61% and post-partum family planning (PPFP) uptake which is unmet need, maternal mortality at 362/100000 live births, with a neonatal mortality rate at 22/1000 live births (25) and eradicate gender based violence, FGM and teenage pregnancy/ early marriages which are harmful cultural practice in line with universal health coverage (UHC) (17).

Health facility community dialogue forms a forum whereby the health care provider (HCP) takes the pregnant mother/partner and community through services offered in ANC, labour ward and Post Natal (PN) care plus other services the hospital offers with their rationale (1,2,3,9,22,24,32). Every day there are maternal mortalities of about eight hundred women globally due to pregnancy or complications of birth with Sub-Saharan Africa accounting for 99% of the deaths, (4,5,7, 8, 9, 11). Many of the complications that result in maternal mortality and perinatal deaths are complications of PPH as the leading cause, abortion, uterine rapture, puerperal sepsis, pre-eclampsia/ eclampsia, (6,8,10). Delays in response to danger signs, labour and other obstetric complications, by the mother, family and health care provider are a major hindrance to optimal maternal health (1, 12, 14, 18, 24). Lack of awareness, cultural practices and beliefs inhibit preparation for delivery and health seeking behavior. If complications occur in unprepared mother or family more time is consumed in understanding the complications, decision making, transport seeking and reaching the health facility (first delays) (1,7,15,20), birth preparedness with male involvement is key in averting the first delays, which can be achieved through health facility community dialogue (17,40, 41, 43).

In Africa the role of child bearing is assumed to be a woman affair, yet the male spouses/partners are the decision makers and are more economically empowered than women (18). When pregnant women and their male partners are given health education together there is a greater net impact on maternal health seeking behaviors, compared to educating the woman alone. There is limited data on male involvement in birth preparedness at national level through health facility community dialogue. Therefore; this research will explore level of male involvement in birth preparedness through health facility community dialogue in Kajiado county Kenya, which will inform the policy makers, program coordinators, health professionals, stakeholders, communities, mothers and their partners on status of male involvement in birth preparedness nationally, at county and at household level.

1.1 Statement of the Problem

Male partners in the society are key influencers of maternal health outcome due to their financial power and cultural endowment that male figure command in the society and this can be achieved by involving them in birth preparedness plus the pregnant mother through open maternity days which forms a forum for health facility/ community dialogue. Kenya maternal mortality is at 362/100000 live births which is below the WHO recommendation of maternal mortality of 147/100000 live births and SDG of less than 70/100000 live births. The infant mortality rate is 39/1000 live births, under five mortality rate of 52/1000 live births and new born mortality rate of 22/1000 live births (25). Kajiado County has a maternal mortality of 495/100000 live births and infant mortality of 40.2% above the national levels of 39/1000 live births and 362/100000 for mothers (25). Pregnancy and child birth complications cannot be predicted, therefore; anticipation and preparedness should be in place to ensure maternal and newborn safety. A pregnant mother's death with her unborn child or newborn is devastating both to the mother, partner, family, community, health care provider and the nation at large. This is supported by International Convention for Population Development -ICPD 2025 (17), on zero maternal and zero newborn deaths. In African society, child bearing role is associated as a female role with male only involved in the periphery, coupled by cultural beliefs and practices.

Despite men's low involvement in maternal health, they greatly influence maternal health. When men are made aware and positively involved in birth preparedness there will be a major impact in maternal newborn outcome. Currently in Kenya and more so in Kajiado County, there is no data to show the level of male involvement in birth preparedness, also researches done before on factors influencing utilization of free maternal care services have recommended birth preparedness as a key component to increasing maternal health utilization because according to Maasai culture it's a taboo to have a birth plan as birth is viewed to be natural (22). According to WHO, MOH Kenya, revised quality of care obstetrics and perinatal guidelines, maternal newborn health quality of care standards, assessment and quality improvement tool recommend maternity open days and health facility community dialogue in order to improve maternal health outcome where the males and community are key components.

1.2 Research Objective

To explore the factors that influence birth preparedness among male partner in Kajiado County-Kenya.

2.0 Literature Review

2.1 Health facility community dialogue

Health facility community dialogue is a concept whereby the pregnant mother, her partner, family and the community are provided with an opportunity to visit and tour the maternity unit, meet with Health care providers (HCPs), and also the HCPs move to the community and interact with it. Through this they tend to interact with the health care providers one on one, learn about choice of birth place and see services offered in maternity. Information on preconception care, breastfeeding, health and wellbeing, Insurance services/Linda mama package, birthing positions, danger signs in pregnancy, nutrition in pregnancy and other services relevant to pregnancy are given. Health facility community dialogue forums/ maternity open days are not well formulated and articulated in Kenya government public health facilities to facilitate birth preparedness and encourage more mothers to deliver in hospitals and also involve the male partner and community in maternal health.

This concept is being introduced by the WHO (40,41,42,43) in conjunction with MOH in government health facilities in order to increase respectful maternity care. This also forms a basis for the public health facilities to showcase what services they offer in maternal health and increase facility birthing in order to utilize the free maternal health care services being offered in government health care facilities and increase maternal service indicators like ANC more so, fourth ANC visit which is at 52% nationally KHIS (2019), skilled birth attendance and targeted postnatal care coverage together with post- partum family planning. This will increase delivery from 66% KHIS 2019 to MOH target at 70% by 2030, and 62% KDHS 2014 (25), to recommended WHO, (2019) over 95%. In order to attain the maternal and newborn care indicators of ICPD, 2025 (17) of zero preventable maternal deaths, zero perinatal deaths, zero unmet needs (FP) and zero cultural practices that are harmful (FGM, gender based violence and early teenage pregnancy/marriages), to align with UHC and Kenyan vision 2030.

Key priority indicators are maternal mortality ratio which stands at 362/100000 live births, skilled birth attendance at 62%, 4th antenatal attendance at 52% nationally, targeted postnatal care coverage which stands at 58% and FP as unmet need at 61% (25,28). This can be achieved through the concept of health facility community dialogue by involving male partner in birth preparedness plus the community. Health facility community dialogue is a new concept that has never been practiced in public health facilities but it's been incorporated in the WHO maternal newborn quality of care standards and revised national quality of care obstetrics and perinatal guidelines, (2020) in order to improve on maternal /neonatal quality of care by the Kenyan government. The government through community health strategy needs to mobilize, advocate and sensitize the male partners on importance of male involvement in birth preparedness. The community is taken through pregnant mothers' health rights, myths and misconceptions about skilled delivery are spelled out, and the community with the health facility comes out with solutions to issues affecting maternal health. This leads to increased 4th ANC uptake, increased skilled delivery thus reducing maternal and perinatal morbidities and mortalities.

2.2 Male Partner Factors Influencing Birth Preparedness

Male Perception

Interventions on birth preparedness has previously focused on mothers with several interventions on maternal health excluding the male partner yet males have the economic will (20,21,27,29). Cultural beliefs and practices where males are not supposed to attended ANC or delivery and health system factors like lack of space/privacy in ANC and labour ward to accommodate male partner have contributed to male partner perceiving maternal health to be a women's affair. Policies that do not in cooperate males in maternal and new born health need to be addressed (40,41,42,43).

Communication amongst Spouse

Poor communication between couples' limits birth preparedness for both the mother and the male partner (30, 33, 34, and 39). In case of an obstetric emergency the chances of getting first delay (lack to recognize danger signs, lack of prompt decision making, cultural value/ beliefs) will lead to second delay (lack of transport to health facility) which is coupled by men being the financial pillars in the society and decision makers. Where there is poor communication there are high chances of intimate partner violence which may be physical, psychological, social or even spiritual, which may lead to poor pregnancy outcome (44, 45).

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Male partner age

Older age and if cohabiting is associated with male involvement. This tends to concur with a study done in Kinshasa that found male involvement to be 1.2 times higher among men whose female partners were 25 years and above. Partners who are in monogamous relationship and cohabiting men were twice and 1.6 times more likely to be involved in birth preparedness. In contrast a study done in Ghana (33), which showed that men in polygamous relationships had a higher involvement in maternal health.

Education

Level of education influences male involvement in birth preparedness. A study done in Uganda reports that men who had completed eight or more years of schooling, had formal occupation and if mother/spouse experiences pregnancy complications, males are more likely to be involved in birth preparedness (16,22,33). Birth preparedness starts from preconception to include knowledge on preparation for pregnancy, recognition of danger signs during pregnancy, labour and postpartum period, mode of transport during labour, arrangement for skilled birthing, someone to assist the mother during labour or in exclusive breastfeeding, setting some funds aside for emergency and registering for Linda mama package, a decision maker during emergency (43).

When a mother is diagnosed with a condition like anemia, if the husband is accompanying the spouse to ANC, health education will be given on importance of healthy feeding, in this case it's the man who is the financial pillar and therefore he is more likely to buy the pregnant mother the food needed to boost hemoglobin level unlike when the mother is unaccompanied. The Linda mama package does not include point of care ultra sound/ANC profile financing. Therefore, when male partner accompanies their female partner to ANC, he is able to finance for the investigations.

Male Spouse Economic Status

Social demographic factors are contributors to birth preparedness (2,4,16,22,23,29, 32). Low level of education, non- formal employment, occupation, distance from health facility, high parity or teen pregnancy, number of ANC visits attended affect birth preparedness. Male spouse economic status and education on danger signs, obstetric emergencies, registering for Linda mama package, will help reduce delay in decision making and seeking health care services (11, 32). Utilization of individualized birth plan will assist the couple to save money for delivery, arrange for means of transport, organize for whoever will remain with other kids when the mother goes to deliver, choose whoever she would love to accompany her to hospital for delivery (duala), who will be an eligible blood donor and above all choose the preferred health facility of choice hence delivering under skilled birth attendant. (34,43,45).

Studies done in Edo Nigeria and Burkina Faso respectively, reports that education level and occupation were determinants of birth preparedness, older age, formal employment and higher social status were associated with birth preparedness.

In a study done in Ethiopia parity was a great determinant on birth preparedness (3,6,15). Risk for developing obstetric complications during pregnancy like pre- eclampsia and eclampsia are more common as the reproductive age advances. Age at first birth and number of live births are associated with birth preparedness and utilization of birth under skilled birth attendant. A woman's parity, number of ANC visits and knowledge were associated with birth preparedness. Studies done in Ethiopia, Nicaragua and Nigeria showed that pregnancy complications like still birth, obstetric fistulas, maternal morbidity in previous pregnancies were greatly associated with birth

preparedness, also the studies advocated the role of the male partner in birth preparedness (1,3,6,8,16).

2.3 Conceptual Framework

The conceptual framework in Figure 1 shows the link between independent variable (male partner factors) and the dependent variable (male involvement in birth preparedness).

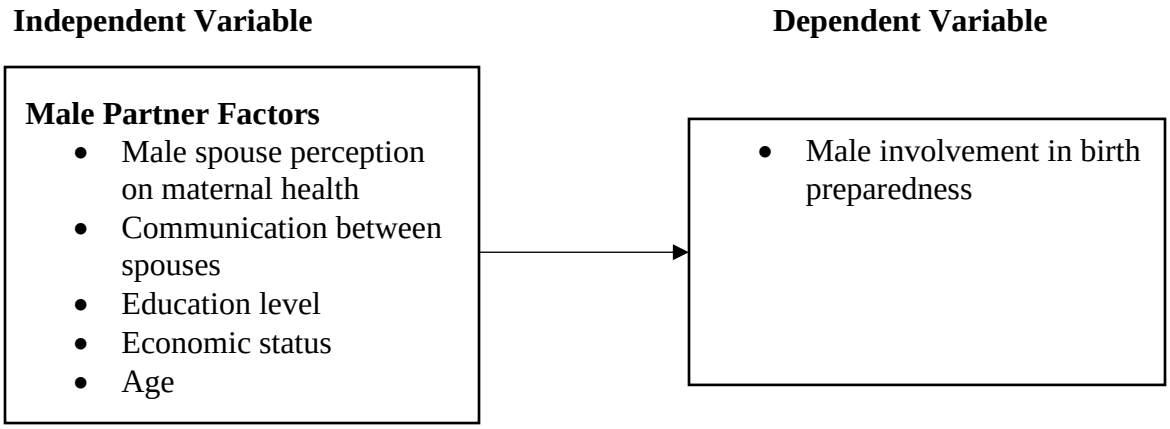

Figure 1: Conceptual Framework

3.0 Research Methodology

The study employed explorative-descriptive qualitative research design. The target population was households with male partners/spouses, married men who had children aged 0-2 years, aged 18 years and above. The sampling technique was purposive sampling technique to select households. Three groups were used, with each group consisting of 6 members a total of 18 participants until saturation was reached. Data was collected through structured guided interview on focused group discussions on male partner and structured guided interview administered questionnaires on community health volunteers who were used as key information informants. A total of three focus group discussions were held with a total of 18 participants and a total of 2 community health volunteers were interviewed. All the concepts were checked for inaccuracies, completeness, errors and omissions and the data was sought into themes, categories, patterns, relationships and analyzed using narrative analysis.

4.0 Results and Discussion

4.1 Male Partner Factors

The study explored subthemes for male partner factors like perception, age, educational level, communication between spouses and economic status.

Perception

Regarding perception of male partners on maternal health there were mixed perceptions and reactions elicited, majority of the participants expressed their feelings that maternal health is regarded as a women issue, men come in, in terms of offering financial support and security to the mother while escorting her for birthing to the health facility if it's at night. Culturally the male

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partner offer security to the woman in terms of being regarded as married because by the virtue of being married gives the woman a name and respect in the community because the female partner has to adopt the male partner name, also the baby once born it has to bear the paternal name.

Maasai men believe that they are only supposed to be involved when it comes to giving support in terms of finances, assisting the mother to go to the hospital. They reported that as their culture dictates, they are only supposed to support their wives by taking them to a mukunga or the hospital for delivery and proceed to taking care of their animals, by looking for pasture and water. This is supported by the following quote.

Respondent in FGD group one:

"In Maasai culture we do not talk about the unborn baby; therefore, we do not prepare for birth. We do not accompany our female partners to clinics for the doctor to talk to us about preparation for birth".

"As a young initiated moraans we are only supposed to give our wives money to go to the hospital for ANC or call in a mukunga (Ngaitishoni) during delivery and wait for the outcome, and for PNC services those are purely maternal issue. Maasai culture dictates that once the baby is born, if the delivery was at home the mukunga (Ngaitishoni) or mothers assisting in delivery will come out of the labour room to inform you (male partner) of the baby sex by informing you to through an arrow using a spear in the bull if it's a boy and if it's a girl you will pears the cow, then you pay the mukunga a fee of either a goat or some money for appreciation.

After birth the mother and child are left under the care of other women, as a man you can only come back to live with your wife in the same house when the baby reaches at least two years and above. Therefore, the mother can practice natural family planning".

This is another speech from respondent in FGD group two

"If am seen on the road with my pregnant wife going to the hospital for ANC, or for PNC services, people will laugh at me and think that am a weak man." This was echoed by a big laughter and agreement by the rest of the participants in the group. But a few of the participants in FGDs felt that it's good to be involved in maternal health because the /CHVs have educated them on that.

This is a quote from responded in FGDs group three:

"The CHVs have taught us on the importance of taking our pregnant partners to the hospital. We were also told that our pregnant mothers should eat well."

Partners Age

Majority believed a partners age doesn't influence involvement in birth preparedness because Morans are prepared for marriage therefore by the time one becomes a Moran they understand their roles to the family but the culture does not really dictate involvement in birth preparedness because the Maasai culture will not allow discussion of unborn baby or whichever preparation for unborn baby whatsoever , but for a few who were of the contrary opinion believed that sometimes a spouse age can influence ones thinking hence lead to involvement in maternal health.

This is a quote from one of the respondents from FGDs one

"*We take our boys to be morans from at least the age of fifteen to eighteen years of age or above. As morans they are supposed to take care of the security for the community. Someone who is able to take care of security for the whole community, he is assumed fit for marriage". M*ajority of the respondents agreed that once one is in a position to offer security to the community, protect animals

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from cattle rustlers or wild animals, then he is equally fit to marry, this was supported by the following quotes.

Quote from a respondent in FGDs two:

"You *need to marry early because one needs children to take care of the animals, also our boys do not pursue higher learning due to little resources. Therefore; they drop out of school due to lack of school fee and resort to taking care of animals. The government does not take care of boy child education the way it does for girls."*

Communication with Partners

Many believe communication is key though some of the respondents believe culturally any discussion on unborn child is going against the cultural norms, values and beliefs, they believe women should be talked to and if they do not follow instructions women should be beaten once in a while when they make mistakes because it's one way of keeping checks and balances to ensure that the women remain faithful to their husbands and the women love it. If they are not beaten, they feel something is wrong maybe their husbands do not love them.

This was supported by some of the quotes as follows:

Respondent in FGDs group one

"Sometimes we are forced to beat our women as a sign of love, if we do not discipline them they might feel we don't love them. So beating them is one way of communication and instilling discipline".

Respondent in focused group two

"It's good for couples to engage in communication, though according to our culture we do not talk about the unborn baby until the baby is born. Any communication on birth preparedness we do not engage in that, this is because we believe there are angels guarding the unborn baby while in the womb, so you do not need to form a discussion over preparing for unborn babies, as long as the mother is well".

Respondent in focused group 3

"We do communicate in the family but no discussion is formed on the unborn baby, what should we be discussing on someone who is not yet born, we will discuss later after the baby is born".

Education level

The team agreed that the level of education was low among the Maasai community with high levels of poverty and school dropout. This were some of sentiments from one of the respondents in FGDs group one who is a village elder for manyatta kumi:

"Level of education among us is low, most of our boys don't go to school the government has concentrated more on girl child education through support in terms of sponsorship. Each area chief is supposed to take report to the chief's office on monthly basis on the number of girls who are in school, teenage pregnancies, early marriages and those who have dropped out of school. Then the area chief forwards it to the sub-county education office by 5th of every month, the information will be forwarded to the county education office then later to national government by 15th of every month as a directive by the education CS professor Magoha for understanding the status of girl child education in nomadic communities. This is so because during the covid-19 lockdown of schools in March 2020-January 2021, most of the girls were affected with teenage pregnancies and early marriages which caused uproar in the country, our community was very much affected ".

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This statement from the village elder (nyumba kumi) was echoed by education officer in Kajiado county who stated that, opening of first term 2021 in July most of the girls never reported to school therefore the government has started a campaign to mop all manyatta house-holds to check on the number of girls in school and those not in school and given a directive for all girls to be housed in schools in order to keep them in schools as a way of reducing girl child drop out from school. A total of 28,678 school going children were to report to school when schools reopened in first term 2021 but 21 167 school going children never reported, this has been coupled with poverty and lack of community sensitization on education.

They reported, that the boy child education is compromised in the county due to high levels of poverty, cultural aspects of nomadic life of moving from place to place looking for water and pasture with no other economic activity to depend on to raise fees.

They agreed that the level of education will lead to one being economically empowered therefore be in a position to provide to the family.

This is a quote from respondent in focused group three:

"O*ur boy child is disadvantaged; the ministry of education has neglected our boy child. If we have education, we are able to get jobs then we will be able to feed our children and take them to school". When you have education you are able to take your wife to maternity clinic, our boys drop out in primary school. Most of them do not finish class eight due to lack of school fee. This leads them to drug and substance abuse, early marriages that break at an early age, our boys are suffering the government has neglected them".*

Economic Status

If one has finances, he is able to support his family in terms of daily needs, he will be able to support his wife by providing for means of transport to the hospital and pay for other expenses in the hospital like ultra sound, lab requests but if one does do not have finances he has to rely on the traditional birth attendants because he will only pay a goat which is affordable because they are available.

This is a quote from a respondent in FGDs group one:

"If we are economically empowered we may assist our partners in birth preparedness but we do not have jobs the government has forgotten us, we struggle to take care of our families, daktari when you came you, just found us seated hear under the tree, the government has forgotten us?"

A few of the respondents believed that being economically empowered they can participate in birth preparedness.

This is a quote from respondent in FGDs group two:

"The nature of our work is to take care of our animals looking for water and pasture. This is our economic empowerment, because we travel for many kilometers looking for water and pasture we may not be able to be near hospitals to take our wives to hospital during pregnancy and be taken through birth preparedness".

Majority of the respondents believed that being economically empowered is needed for them to support their partners with finances to hospital, they felt birth preparedness is more a women issue unlike being for both though they reported that if economically empowered they can finance their pregnant partners to hospital for ANC or delivery.

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4.2 Discussions

Male partner factors

The findings of this study revealed that male involvement in birth preparedness through health facility community dialogue was not comprehensive. The males were periphery involved in terms of providing finances, this tends to concur with other studies done in Iran, Malawi and Rwanda (5,11,14). The Keya Maternal and perinatal death response and surveillance Report (2021) showed that first delay due to lack of family knowledge to recognize danger signs in pregnancy and take prompt action stood at 64% nationally. The aspect of health facility community dialogue on maternal health has not been impressed by the Kajiado county whereby the county needs to engage the community through health facility community dialogue through maternity open days on birth preparedness and other maternal health issues to foster respectful maternity care and through this male partners will be informed on importance of birth preparedness which can be achieved if male partners accompany their pregnant partners to ANC where there are health educated together on: recognition of danger signs in pregnancy as follows; per vaginal bleeding in pregnancy, convulsions /fits, severe headache with blurred vision, fever, fast or difficulty in breathing. Once the couple recognizes danger signs in pregnancy, they will have a prompt decision making to seek health care to avert first delays in maternal health that may lead to complications in pregnancy, morbidity, mortalities or poor pregnancy outcomes (40,41,43). Due to low ANC attendance, the 4th ANC attendance stands nationally at 52% (KDHS, 2014). The issues that will be addressed through such forums on birth preparedness during ANC or maternity open days are arrangement for skilled delivery by choosing a health facility of choice for delivery, choosing a birth companion, arrangement for blood donor in-case of an emergency, a decision maker in-case of an emergency, arrangement for the person to remain with other children as the mother goes for skilled delivery (6, 9, 43).

The health facility needs to show-case what they offer on maternal health by taking the community to maternity units and take them round the unit. The community engages the health facility in a dialogue by complementing or critiquing services offered in maternal health, and also the HCPs engage the community on ways they feel they need to improve their services. Days are set on when the HCPs can visit the community to assess maternal health matters in the community and how they impact health care (28).

The project on open maternity days through health facility community dialogue is spearheaded by ministry of health through support from global fund. The Kajiado county health department reported that they have no funding or factored this aspect in their annual health budgets for maternity open days to foster respectful maternity care and engage the males in birth preparedness due to low budget allocation from treasury. Therefore; there is no forum on health facility community dialogue due to lack of funding for the activity which should be done on quarterly basis annually. Through this forum the HCPs educate the community on their reproductive health rights, myths and misconceptions are misspelled out and the community becomes familiar with what services are offered in maternal health. In-case the community is aggrieved with services offered to them clarity is done, reconciliation between HCPs and the community is focused in-case there is an issue. Also this forms a forum whereby solutions to problems affecting maternal health delivery both at community and health facility level are addressed. Male partner and the community at large are encouraged to support maternal health.

This study concurs with previous studies done in Ghana, Nigeria, Ethiopia and Nepal which reported that lack of community engagement in maternal health, and poor funding for health leads to poor pregnancy outcome (6,9,12,27).

The Bamako initiative, (1998) in Mali declared every country to allocate 15% of its GDP to health. This is in contrast to Kenyan situation where the annual budgetary allocation for health is at 5.8% of its annual GDP (40).

Linda mama reimbursement for every delivery should be able to improve infrastructure, enable availability of maternal health supplies like uterotonics, non-pharmaceuticals for maternal health., but this is in contrast of the government intention because the Linda mama allocation goes to county health account which makes it impossible for the Linda mama reimbursement to be felt at the point of maternal service delivery, this has compromised quality of care in maternal health leading to increased maternal, and perinatal mortalities due to third delays. (40).

The county has no forums to engage male partners in birth preparedness through health facility community dialogue apart from CHVs being trained on maternal health issues where they teach on importance of ANC attendance and skilled delivery. HCPs should be actively involved in community engagement and dialogue because it's the only way of doing needs assessment and evaluation of maternal health services offered to the community, this concurs with a study done in South Africa on the role of CHWs (4).

There should be a shift from HCPs awaiting for the community to seek their services in the health facility, but the health care facility should be able to market their services to the community to increase health service uptake through the community health strategy (40). Male involvement in maternal health within Kajiado County is generally low with most males not aware that their involvement is a key component in birth preparedness that will highly impact on pregnancy outcome.

Masaai culture is more patriarchal, this is supported by research done in Ghana, Central Ethiopia and Bangladesh on male involvement in maternal health which reported that most males did not understand birth preparedness because they never took their pregnant mothers for ANC (1,2,9).

This is supported by other researches that have been done globally that shows male involvement in birth preparedness is a determining factor for health of mother and pregnancy outcome because males are decision makers in the society, they are the financial pillars in the community, they offer security to the family, they decide when intimacy occurs, size of family, what the family eats and when the pregnant mothers can seek health care services like ANC, skilled delivery and PNC (23,32,38).

Male Partner Perception

The study results showed that majority of the respondents felt maternal health is a woman issue though they provided security to the woman due to the area being prone to insecurity and cattle rustling, gave the woman a name for the virtue of adopting their name once married and they offered finances and advice. This tends to concur with other studies that have been done before which showed male partners involvement in birth preparedness was viewed to be women issue (8, 15, 26,27).

The issue of male involvement in birth preparedness was a new thing to them even for the few who had managed to accompany their partners for ANC, they did not understand the components

on birth preparedness, none of them in the focused group discussion was in a position to state danger signs in pregnancy and what to do to prevent first delays nor mention any component on birth preparedness model as per WHO, 2008. This agrees with a study done in Bangladesh and Nigeria that reported male partners felt maternal health issues were feminine (14,15,27).

Lack of birth preparedness leads to first delays hence increase in maternal and perinatal complications, morbidity and mortalities in the country, (24, 39). Accessibility to health care facilities is difficult due to poor road networks making it impossible to access the health care facilities, then the availability of maternal health services is a problem at night and weekends due to shortage of staffs which contributes to second delay. Planning for preferred health facility is difficult due to lack of accessibility and availability of the services for skilled delivery. Other components for birth preparedness like arranging for transport, setting funds aside for emergency, looking for a birth companion as the woman goes to deliver, looking for someone to take care of the other children when the woman goes to ANC, delivery and PNC services, blood donor incase the mother develops PPH and enrolling the mother for Linda mama package is wanting, this concurs with other studies done (2, 11,44,46). The male partners need to understand their role as key decision makers and being financial supporters that their involvement in birth preparedness will improve pregnancy outcome (43).

Communication

In this study communication was a challenge due to the nomadic lifestyle of looking for pasture and water which sometimes made families to be apart. This tends to agree with previous researchers done before which showed that communication impacts on the outcome of the newborn as some decision have to be discussed together as a couple (1,4,8,22,24,34).

Male Partner Age

On male partner age and economic aspect with its impact on birth preparedness, the respondents reported that according to their culture one is initiated to be a Moran from age fifteen years and above and they believe once initiated as a moran one is in a position to marry and take care of the family, these results tend to disagree with previous researches done before which suggests that age is key in influencing decision making in marriage which impact maternal health outcome. Researches done before in Nepal, Tanzania and Nigeria on male involvement in maternal health reports that males who are twenty-five years and above are more likely to be involved in maternal health unlike the younger ages (4,30,34).

Educational Level

The respondents linked level of education to economic empowerment, they agreed that the level of education in the county was low especially among the boy child due to poverty leading to school dropout and early marriages with boys engaging in alcohol and substance abuse. The study results tend to concur with other researches done in Uganda on male involvement in birth preparedness which showed that males who had attained eight years of education or more are six times more likely to be involved in birth preparedness ((16,36). Due to low literacy levels in the county which stands at 42% compared to national level that is at 81.5%, the county has annual budgets for adult learning classes per sub-county, but the enrollment is low in male partners who believe adult education belongs to women, and their culture does not allow them to seat in the same adult class with women (21,22,25).

5.0 Conclusion

The study concludes that male partner perception, level of education, age at marriage, communication among partners and economic status had an influence on male partner involvement in birth preparedness negatively or positively. Communication was low, this was influenced by the nomadic culture, leading to poor pregnancy outcome.

6.0 Recommendations

The county government of Kajiado to come up with community engagement forums to dialogue with the community on birth preparedness through open maternity day forums and change the male perception on birth preparedness.

The ministry of education to empower the boy child by retention in school, the way it has system in place to track the status of the girl child in school for nomadic communities, this will avert early school dropout that leads to early marriages and high index of poverty levels

The community to engage in other forms of economic development other than cattle rearing to cater for their daily income.

The male partners to foster communication between spouses to improve on pregnancy outcome.

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