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Gender Perspectives in Access and Utilization of Reproductive Maternal Neonatal and Child Health Services In Rural Western Kenya

Geoffrey Otieno Muga

Institute of Anthropology, Gender and African Studies, University of Nairobi, Kenya

Abstract: **A rapid gender analysis using qualitative methods of data collection was undertaken in Siaya County, rural Western Kenya to understand the local context and assess gender equality in reproductive, maternal, neonatal and child health. Study findings indicate that gender roles and responsibilities for both men and women are clearly defined among the rural Luo community of Siaya County. Women are expected to "take care" of the home and are thus viewed as "home managers". They are also expected to undertake productive work such as farming and income generation to support the family. On top of these are the reproductive roles which the study revealed are the most valued roles for women in the community since they guarantee continuity of the family, lineages and clans. These include giving birth, taking care of the new born, upbringing of the children and providing health care to the children. Men's role among the Luo are mainly found outside the home and include providing food and shelter to the family and assuming security, leadership and decision-making responsibilities at home and in the community. Findings showed that despite modernization with its attendant changes in knowledge, attitude and practices in various spheres, women's roles are still confined at home, undervalued and having little authority as opposed to those of men which accord them control, power and authority in decision-making over women and resources. Furthermore, the study found out that the triple role of women constitutes role overload with far-reaching health repercussions for women and children. Women take up close to 70% (16/24 hours) of their full day time performing domestic, reproductive and community roles a situation that was found to constrain their time for accessing and utilizing maternal and child health services available in health facilities. Most women also expressed that they are often left with no time to maintain proper dietary preparation and consumption practices during their pregnancy and also for the wellbeing of their infants and younger children. Women's unequal social status limits their ability to space their children and negotiate for safe sex with their husbands or intimate partners. This increases their vulnerability to violence and cases of unwanted pregnancies. Harmful gender norms and attitudes deriving from pervasive gender inequality underscore the problem. Compounding the situation is the finding that a majority of women do not have control over productive resources and have to rely on the support of the men to enable them to pay for healthcare services. This dependency means that access and utilization of health services may be delayed for the mother and child should the man fail to pay for medical costs to pave way for a clinical visit in good time. Finally, although women and men concurred that they have equal rights to health services, the study found out that men tend to shy away from some services such as fortified meals and other nutritional supplements in cases of malnutrition mainly because of stigmatization and gender norms reasons. The study recommends sensitization and awareness creation on health rights for both men and women through facility-based and community level forums. Building the capacity of men and incorporating them as change agents in health interventions would also enable them to appreciate their important role in supporting women to access and utilize reproductive, maternal, neonatal and child health services.**

Keywords: **Gender equality, reproductive, maternal, neonatal, child health, gender roles, gender analysis.**

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I. INTRODUCTION

Gender relations among the Luo of rural Western Kenya:

Gender inequality is prevalent in Siaya County despite article 27 (3) of the Constitution of Kenya 2010 which provides for the rights of women and men to access equal treatment including the right to political, economic, cultural and social services. Siaya County Government acknowledges the importance of improving equity and reducing gender disparities as this has potential of benefiting all sectors and thus contributing to sustainable economic growth, poverty reduction and social injustices. As a result, the County government has developed deliberate policy interventions geared towards gender mainstreaming in all its programmes by cascading and incorporating the country's constitutional provisions to the County development strategies. For example, Siaya County Government has formulated a Public Participation Policy which spells out the modalities of citizen participation including women and the disadvantaged in governance processes such as planning and budget-making for health sector.

Despite the above efforts, gender inequality is still prevalent in Siaya County. For example, although the proportion of women is higher than men in the County, the resource distribution and ownership is skewed towards men. In agriculture for instance, while women provide 65 per cent of the farm work force, they own less than one (1) % of the land and resultant family income from the sector (Siaya CIDP 2013-2017). The plan identified weaknesses and threats that accelerate gender inequality like; skewed ownership and control of productive assets which is dominated by men, over-burdening gender defined roles that hamper women participation in social and economic spheres and inadequate participation of women in decision making processes. Cultural beliefs, gender-based violence and political dominance by men are some of the factors that threaten the realization of gender equality and equity in Siaya County.

The County currently has a total of 149 health facilities, 120 of which are public facilities (about 80% of total facilities). The 120 public facilities consist of one county referral hospital, six sub-county hospitals and 113 primary health care facilities (Siaya CIDP 2013-2017). In addition to the health facilities, health services in the county are also provided by the current 187 existing Community Health Units. A community health unit is a health service delivery structure within a defined geographic area covering a population of approximately 5,000 people. Each unit is assigned 2 Community Health Extension Workers (CHEWs) and community health volunteers who offer promotive, preventative and basic curative services. Each unit is governed by a Community Health Committee (CHC) and is **linked to a specific health facility**. The role of a community health unit is to bring services closer to the people that need them. About 147 mission facilities and 82 private facilities serve the population in Siaya County. There exists a proportion of the population who seek medication from traditional medicine men and herbalists.

The Kenya Demographic and Health Survey (2014) estimated that the total fertility rate for Siaya County is 4.2 against the national average of 3.9 while the current use of any method of family planning (% of married women age 15-49) was estimated to be 55% against the national average of 58%. The survey further revealed that more deliveries are usually attended to by skilled personnel and health facilities (at 70% against the national average of 62%). Contraceptives prevalence rate in the county is 45%. This is due to myths and misconceptions on contraceptives, socio-cultural practices and access to health facilities.

According to the Kenya Integrated Household and Budget Survey (2005/2006), 22.79% of the children in the County below 5 years are stunted, while 12.6% of the children in the same category are underweight. Malnutrition seems to be common for children under 5 years who are either severely or moderately stunted estimated to be between 25-26% (KDHS, 2014). Siaya county is also among the counties in Kenya with the highest infant and child mortality rates (estimated at Under 5 five Mortality Rates: 102/1000 and Infant Mortality Rates: 113/1000).

The Kenya Constitution 2010 that established a devolved system of governance in Kenya identified health as one of the functions to be devolved from the national government to the counties. As such, provision of health services for Siaya county residents is placed under the armpit of Siaya County Government headed by the Governor and his team of executive members. This transition to devolved health care system has not been without challenges and Siaya is no exception. Delays in fund transfer from the national government to the counties have resulted in strikes by the county health professionals and this has on many occasions caused a lot of suffering to those in need of health care mostly mothers and children. Compounding the situation is gender inequalities between men and women which deter most women from accessing and utilizing reproductive, maternal, neonatal and child health services found in medical facilities.

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II. BODY OF ARTICLE

METHODOLOGY:

Study location:

Siaya County is situated in the western region of Kenya, along the shores of Lake Victoria (figure 1 below). It is bordered by Busia County to the north, Kakamega and Vihiga Counties to the northeast and Kisumu County to the southeast. The county is about 400 Kms from Nairobi-the capital city of Kenya. It covers an area of 2,350 square kilometers with a population of 842,304 people as per 2009 census (KPHC, 2009). Politically, it is organized into 6 constituencies (also called sub-cuonties) namely: Ugunja, Ugenya, Alego-Usonga, Gem, Bondo and Rarieda. The rapid gender analysis targeted two sub-counties of Ugunja and Alego-Usonga.

Demographic and other socio-economic characteristics of Siaya County:

The County is endowed with many resources, but has been a low producer of goods and services, a situation that has contributed to the prevailing high poverty levels. The factors that have led to the low productivity include the values, attitudes and work ethics that run counter to the spirit of entrepreneurship and wealth creation. Low industrial investments in the county have also contributed to low productivity.

According to the Kenya Population and Housing Census (KPHC) of 2009, the total human population of Siaya County was 841,682 persons, 52.6% of whom were women. This population is projected to increase to 964,390 (456,441 males and 507,949 female) and 1,070,797 people by 2017 and 2020 respectively at a growth rate of 1.7% per annum. The average population density is 12 persons per km2. A majority of the population (about 65.3% of the entire population) are people aged below 24 years of age with about 149,566 people (74,467 female and 75,099 men) aged below 5 years. The population is comprised of more females than males, a factor that may be attributed to low life expectancy rate of 38.3 years for males as compared to 43.6 years for females (Siaya County Integrated Development Plan (CIDP) 2013-2017). The Luo, are the majority but there are few traces of the other sub-tribes particularly the Luhya who have inter-married. Christianity is the dominant religion in the County, although a few households embrace Christianity blended with African traditional beliefs and practices.

The overall poverty level (absolute poverty) of the County stands at 47.56% (KIHBS, 2005/06). Forty percent (40%) of the total population in the County is living below the poverty line. The most impoverished people include Persons Living with Disabilities (PWDS), People Living with HIV and AIDS (PLWHA) and the youth who have a negative attitude towards non-formal employment. While the overall poverty level has reduced significantly, there are still many locations in the county with high poverty ratings. The root causes of poverty in Siaya County are diverse and include poor soil fertility leading to low yields, low income among households, over-reliance on traditional methods of farming and lack of alternative sources of income (Siaya CIDP 2013-2017).

Economic activities:

Agriculture and fishing are the main economic activities of the county with some pockets of petty traders, small scale traders, retail and wholesale commercial activities within the main urban centres. The County is endowed with good soils and climatic conditions suitable for agriculture and livestock production. However, most households in Siaya County experience rampant food insecurity (Siaya CIDP 2013-2017). Most households practice subsistence agriculture tilling small parcels of land and growing maize, beans, cassava, sweet potatoes, bananas, ground nuts among many others. The county produces food that can last only for nine months in a year hence have to look for the three month shortfall from the neighboring counties. The main causes of low agricultural production include; poor crop husbandry, limited area under food crops and unpredictable rainfall, negative cultural practices associated with land and other resource use, low adoption of agricultural technologies by farmers, high cost of farm inputs, erratic demand for agricultural produce, and pests and diseases which result in high post-harvest losses. Food poverty for Siaya County stand at 34% of the population implying that about 286,383 people do not have access to adequate food supply throughout the year. More than 65% of the labor force working on farms is comprised of women. Fishing is done mainly by men in the nearby Lake Victoria with women earning their living by selling fish along the beaches and within major urban and small centres.

Siaya County, just like other counties in Nyanza region, has high prevalence rates of HIV and AIDS, which stand at 17.8%. This has led to an increase in the number of child headed households, Orphans and Vulnerable Children (OVC), loss of productive labour force leading to low productivity and increased school drop-out rate as the older children assume the role of taking care of their ailing parents and their younger siblings. The elderly people have also assumed prolonged caretaking role of those orphaned by HIV/AIDS despite the challenges that they also face in old age (Muga and Onyango-Ouma, 2009). Key issues that have contributed to high HIV and AIDS prevalence rates include; retrogressive cultural practices, high levels of stigma where those infected do not accept and seek treatment on time, high defaulting rates especially those taking Anti-retroviral drugs, ignorance, stigma associated with usage of condoms and high levels of poverty.

Study design:

The study design was cross-sectional and descriptive using qualitative methods of data collection. The study was undertaken in two out of the six sub-counties of Siaya namely Ugunja and Alego-Usonga. The choice of these sub-counties was purposive. On one hand, Alego-Usonga hosts the county headquarters and hence exhibits urban, peri-urban and rural characteristics which were deemed important for gender assessment. On the other hand, Ugunja is predominantly rural and not very far away from Siaya hence has the potential to provide data representative for the other four rural sub-counties

Methods of data collection:

A gender analysis using a mix of qualitative methods mainly Focus Group Discussions (FGDs) and Key Informants Interviews (KIIs) was conducted in Siaya County to understand the local context and assess gender equality with regards to reproductive, maternal, neonatal and child health. A total of six (6) FGDs (four with women and two with men) were conducted. Women FGDs comprised ordinary women, working class women and single mothers interviewed seperately. The FGD participants were purposively selected for the study based on their lived experiences with gender issues at home and community levels. Nineteen (19) KIIs were also purposively sampled for interviews on the basis of their expert knowledge on gender relations at both household and community level and how these impact on access and utilization of health care services. The KIIs comprised public health officials, primary school teachers, traditional birth attendants, nurses, social development and gender officers, community-based organization leaders, women leaders, maternal and child health officers and church leaders. A sample size of 101 participants was reached for both FGD and KIIs (36 men and 65 women) (Table 1). Three FGDs were conducted in each of the two sub-counties while eleven key informants were drawn from Alego Usonga and eight from Ugunja.

Table 1: Number of participants in the gender analysis per category

Method	Category	Number
Focus Group Discussions	Women (Group 1)	13
	Women (Group 2)	14
	Women (Group 3)	12
	Women (Group 4)	14
	Men (Group 1)	14
	Men (Group 2)	15
	Total	82
Key Informants Interviews	Men	7
	Women	12
	Total	19
Total number of participants in the study		**101**

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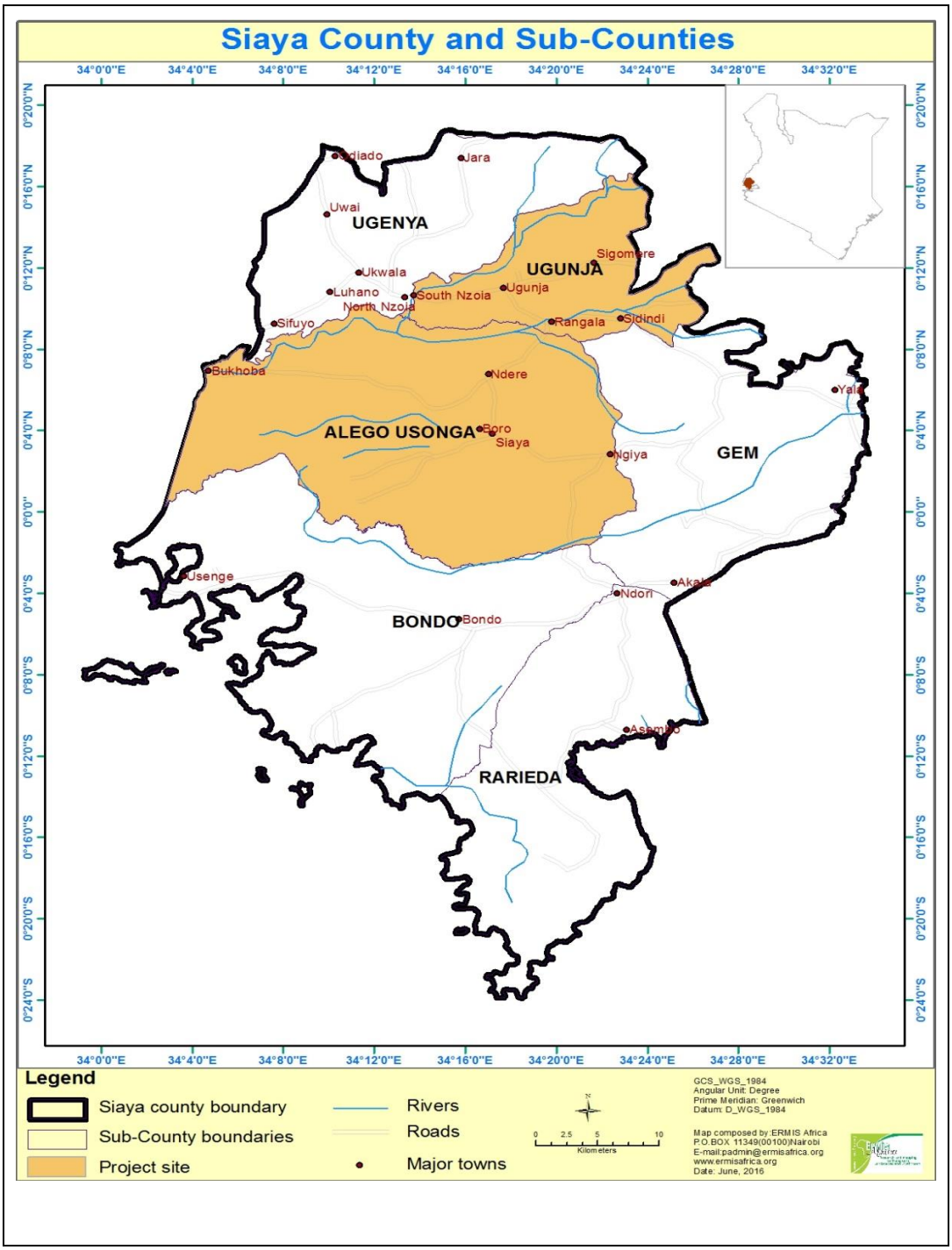

Fig 1: Map of Siaya County

MAIN FINDINGS AND DISCUSSION:

Gender roles in reproductive, maternal, neonatal and child health (RMNCH):

Study findings revealed that gender roles and responsibilities among the Luo of Siaya are clearly defined for men and women. At the family level, the woman's primary role is to give birth to children. She is also expected to cook for the family, clean the house and wash the children. The man's primary role in the family is that of a bread winner. He is also the head of the household and hence is the final authority on family matters. The man's role at the community level is to provide leadership and make decisions on community affairs.

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Focus group discussions with women revealed that at the household level, women are expected to **"take care"** of the home and are thus viewed as "home managers" bestowed with the responsibilities of doing chores like cooking meals, serving food, cleaning the house and fetching water and firewood. They also assume caregiving responsibilities ranging from washing children and taking children to school and clinic for immunization. Furthermore, women are expected to contribute to economic activities such as farming and supporting the husband with income generation either through formal employment or non-formal endeavours such as small scale businesses. Although women contribute a big share of their labour to food production in the household, they only have use rights over the land that they cultivate. Land ownership is bestowed on the man. Study participants unanimously concurred that reproductive roles are the most valued roles for women in the community since they guarantee continuity of the lineages. These include giving birth, taking care of the new born and upbringing the children and taking them to the clinic for scheduled ante and post-natal services. Men's role among the Luo community of Siaya include providing food and shelter to the family and assuming security, leadership and decision-making responsibilities in the community among others.

Data from key informants showed that these gendered roles are culturally constructed and are passed from the older generation to the younger generation through socialization. The clear dichotomy of both men's and women's role is reflective of the patriarchal structure of the Luo community where women's role is confined at home with little authority. This is opposed to men's role which accords them more control, power and authority in decision-making over women and resources. All study participants expressed that the triple role of women (reproductive, productive and community) constitute role overload with far-reaching repercussions on the health of women and their children. Both focus group discussions and key informant interviews revealed that women take up close to 70% (16/24 hours) of their full day time performing domestic and reproductive roles. The participants further expressed that this role overload exerts a lot of burden on women each day to the extent that they may not find time to visit health facilities when sick or for regular ate and post-natal services. Many times they are forced to postpone scheduled clinical visits, a situation which may worsen their health conditions and those of their children (see table on time spent on each role).

Table 2: Number hours spent on reproductive, productive and community work

WOMEN	Hours	MEN	Hours
Domestic/care giving work	16 hours	Domestic/care giving work	4 hours
Income generating/productive	8 hours	Income generating/productive	12 hours
Community work	4 hours	Community work	4 hours
Leisure and rest	5 hours	Leisure and rest	19hours

Source: Qualitative Interviews, 2016

Furthermore, most women expressed that they do not have ample time for personal hygiene and good dietary preparation and consumption practices for themselves and children. Data from key informants indicated that the gendered roles of men give them a perception that they are strong which in some cases make men feel reluctant to go to hospital when they suffer from ailments considered "small".

The study found out that women must seek permission from their husbands who are the ultimate source of authority and controllers of resources to access health services especially family planning services. Should the fail to give consent, the woman would be denied her rights to health. A quotation from a female key informant brings this more clearly:

"Because of a man's decision making role in the household, women may be denied access to health care especially in situations where men refuse to give them permission to visit health facilities. Decision making on family planning issues lie with the man and most women who seek these services without their husband's consent are usually battered by their husbands''. Source: A female Key informant who is nurse.

Study participants expressed that socio-economic factors such as modern education and technology have resulted in changes in the traditional gender roles. Consequently today, as more women are pursuing education and professional careers, they delay getting married which means that those with children become breadwinners and decision-makers in their homes. They are therefore more empowered with the ability to access and utilize reproductive, maternal, neonatal and child health services anytime without consulting anybody. The following quotation by a single woman during FGD with single women brings up this change in roles more clearly:

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"We single women do not need to consult anybody for anything. We make our own decisions. We are the mother and father of our children. If we do not work hard ourselves, then our children will go untreated when sick and hungry and even miss school. We cannot allow that to happen….." Source: A single woman aged 30 working as a school teacher.

Social status of women and men among the Luo and its impact on health decision making at household level

Study data strongly indicated that women and men are not valued equally at household level. Decision making and provider roles which are in men's domain are highly valued than their other roles. For women, child bearing is the most valued role. As one woman said during FGD *"The husband's reproductive role ends at conception only, what follows next is none of his business. The woman will carry the pregnancy for nine months and continue taking care of the child after birth".*

In spite of the high value attached to women's child bearing and other reproductive roles, study participants were unanimous that by and large, women are still viewed as subordinate to men. They are viewed as weak physically and emotionally. The roles they assume are also viewed as inferior with less value to that of men. Men also do not recognize women's roles because they view them as ordinary roles that can be done by anyone. This justification is used to ensure women depend on men for support. Key informants said that this situation leaves men as the sole decision-makers in all realms including health. One female FGD participant said:

"A man makes all decisions at home. Even if you have to go to hospital, you must ask for his permission. Again he is the one who gives money to pay at the clinic. So he dictates everything. If he is uncomfortable with a particular issue like family planning, you cannot access the service''. Source: A female FGD participant.

Women's unequal social status limits their ability to space their children and negotiate for safe sex with their husbands or intimate partners. This increases their vulnerability to violence and unwanted pregnancies. Twelve percent of women reported that their first episode of sexual intercourse was against their will; this figure rose to 22 percent among females who became sexually active before 15 (KNBS, 2010). Harmful gender norms and attitudes deriving from pervasive gender inequality underscore the problem (UNAIDS, 2010). The inability to space children on the part of women limits their potential for personal development and improved quality of life since they are unlikely to have free time for further education and career development.

Study participants were unanimous that both men and women have equal rights to access health services but were quick to add that men tend to shy away from certain services mainly for cultural and stigmatization reasons. For example, one male key informant said that a man diagnosed with malnutrition may fail to turn up to a facility to receive fortified flour and other nutritional supplements since men believe it is the role of the woman to carry the flour back home. This may compromise the health of the man. But the study also revealed that when women have collected the fortified flour and other supplements for themselves and their children, the men demand to use the same foods meant for the mother and baby. *"I am the one who walks long distances to hospital to collect enriched porridge flour for the child but when I prepare it at home, it is the father who takes the child's porridge".* Source: Millicent and Tabitha, Female Key Informants who are health officials at Ambira Health Centre.

Men therefore think that it is the role of women to get the flour for them. The other reason given as to why men do not want to collect the nutritional supplements is because of the stigma associated with malnourishment among adult men.

"When a couple comes to the hospital we attend to them first as a way to motivate the man to keep on accompanying his wife during the clinical visits for their child. But some men tend to discourage others when they accompany their wives with statements such as "dhako oloye"- Luo words meaning .....your wife has power over you". Source a female key informant who is a Mother Mentor at the County Hospital.

The above findings reveal that health workers have devised ways of motivating men to accompany their wives to the clinics by giving them a priority in medical attention. This is meant to break the traditional gender role prescriptions that have left women struggling alone with issues of health care for themselves and children.

Study participants expressed that all men, women and children are entitled to access health care and nutritional services though women have economic limitations that hinder their full access to these services. Coupled with the fact that women are not decision-makers, access to healthcare for themselves and their children may be delayed or refused altogether when consent from the husband is not secured.

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Resource ownership as a determinant of access and utilization of RMNCH:

Study findings showed that among the Luo community, men have access to and control over most productive resources such as land, livestock and cash crops. A quotation from a male focus group discussion brings to the fore the cultural rule that bestows resources into the hands of men:

"All wealth in the home belongs to the man. Even the wife is a man's property". Source: Male FGD Participants.

The above quotation underscores the patriarchal structure that gives men unilateral control of resources in the home and community. This rule has contributed to subjugation of women as all productive resources such land are owned by men.

Women have access to and control low value resources such as farm produce (mainly maize, beans, groundnuts and vegetables) milk from the cows, poultry and household items mainly kitchenware. One female key informant who is a Mother Mentor in the County hospital said that women may have access to resources within the home but may not have control over them. Most valuable resources are owned and controlled by men. All study participants recognized the benefits of controlling resources for men and women. Control of resources enables both men and women to have a voice, autonomy and power to make decisions without having to consult anybody. *"If I have resources I will be able to make very informed decisions in life''* said one female key informant. Ownership and control of resources leads to improved living conditions, economic stability and empowerment for both women and men. It also ensures equality and respect for both men and women. Most importantly, it enables one to meet the basic needs such as health. However, since women do not have control over most resources, they lack the freedom to use the resources for their reproductive, maternal, neonatal and child health needs. Most women have to rely on the financial support from the men so as to seek healthcare services. The fact that it is the man who controls resources means that he also controls decisions related to health care, contraceptives and HIV/AIDS testing and treatment. He also has a bigger influence on the number of children the couple needs to have. This also accounts for the reason why most of the women interviewed said they must consult their men before taking any family planning decision. However, most men would not approve of their decisions for family planning for they argue that they are the ones who take up the costs associated with child care, a fact that is also not usually true as illustrated in the quotation below:

"Low level of education and over-dependency on men for income bar women from accessing reproductive and other health services. Women with low education and economic power are forced to use family planning methods which they would not otherwise use if they were to make their own decisions for fear of antagonizing their men. Women visiting this health facility would say …." just give me an injection form of birth control. My husband will not know that I have been injected". This is the case especially when the husband is rigid and does not take good care of the family thus the burden of raising children is left for the woman". Source: A male Key Informant who is a Nurse in Kaluo Dispensary.

"…what kind of wound is this that takes four months without healing? I cannot wait for my conjugal rights any longer…." Source: Focus Group Discussion with women explaining what their husbands tell them when they ask for sexual intercourse before the healing of the woman after birth.

The above quotation suggests that men do not always want to understand their women's condition after giving birth-a process which leaves the women with wounds in their private parts. They feel it is the responsibility of the women to fulfill their husbands' conjugal rights at all times. Data collected indicated that men could play a big role in supporting women with reproductive health issues if they can also attend ante and post-natal clinics with their wives to get health talks about how to take care of their wives after birth.

The situation above is not any different at community level. Women may be present where decisions are made but again most of the final resolutions come from the men. A quotation from a female key informant presents this situation more clearly:

"We are usually invited as women by county government officials to participate in budget-making process. Like the last time we were invited, we gave our views and even pushed for more money to be allocated to health to help stock the hospitals with drugs. But after deliberations, our views as women were not incorporated. All the resolutions adopted were those of men. We are the ones who look after the health of family members and therefore we are better placed to give recommendations on health service delivery. However, we are usually ignored. This makes women participation in decision-making structures useless". Source: A female Gender and Development Officer with National Government.

Women's right to health is therefore greatly curtailed by the skewed ownership of resources and unequal decision-making power in Luo community. Women's lack of awareness on their right to own property and access healthcare is also a barrier to their empowerment. The other barrier is poverty which affects the health and nutritional needs of the woman and children since women lack the needed purchasing power to pay for balanced diet food and quality healthcare service. Finally, women also face the challenge of male domination in policy making processes which leads to formulation of policies which are unresponsive to the health needs of women, infants and children.

III. CONCLUSION AND RECOMMENDATIONS

This gender analysis has managed to bring to the fore gender perspectives in access and utilization of reproductive, maternal, neonatal and child health services in rural Western Kenya. The analysis focussed on gender roles and responsibilities, participation and decision-making, social status of men and women and control of resources and how these influence access and utilization of RMNCH services.

In conclusion, gender inequality and unequal power relations affect women's access to and control over RMNCH services hence more efforts should be mounted to realize equality for all. The study has shown that role overload has denied women time to attend to their health needs and those of their children in time. Overwhelming tasks at home resulted in some women skipping scheduled ante and post natal services. Male dominance in decision-making has relegated most women to dependants on their husbands for essential services such as maternal health, contraceptive use and family planning. Women are therefore unable to space their children and engage in personal development initiatives aspects that aggravate their marginalization. Inequalities in decision making and power relations were also found to account for women's incapacity to meaningfully participate in local governance processes where health issues are prioritized and allocated budgets. This has led to formulation of policies that are insensitive to the health needs of women and children. Finally, men's health was equally found to be affected by the social norms that confer on them high status that makes them shy away from seeking essential curative services for ailments such as malnutrition.

Based on the study findings, there is need to build the capacity of men through sensitization to enable them appreciate that they have an important role to play in supporting women to access and utilize healthcare services. Moreover, men should be incorporated into public health interventions as change agents delivering health talks and messages that aim to motivate both men and women to share responsibilities in providing better health care for their household members. Sensitization and awareness creation on equal health rights and retrogressive cultural practices, norms and rules that continue to stereo-type and marginalize women will also help transform men's attitudes and practices.

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