

Effects of social cultural factors on male partners' level of participation in maternal and child well-being programmes. A case of Kiambu County, Kenya

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ABSTRACT

Responsibility for uptake of maternal and child wellbeing (MCW) services are a responsibility of both parents however men often play a passive role. Such programmes are doomed to fail in societies where men control family resources and are the family decision makers. This has resulted to high maternal and infant mortality and morbidity rates especially in Sub-Saharan Africa. In Kiambu County low male partner participation in the MCW programmes was identified as a challenge to successful implementation of the programmes. This study sought to determine effects of cultural factors on this low participation. An analytical cross-sectional study was carried out in Kiambu County to establish existing relationships between the variables. Data were collected from one hundred and two male partners. Descriptive as well as analytical statistics were used to establish possible relationships between the variables. The findings from the study revealed socio- cultural factors as significant determinants of the male partners' level of participation in the programmes in the County. The study recommend promotion of male friendly and culture sensitive programmes which may increase acceptability by the male partners leading to their improved participation. This would result to increased consumption of the services by the mothers and the infants.

Index Terms- Male-partner, level of participation, Socio-Cultural factors, Maternal and wellbeing programmes

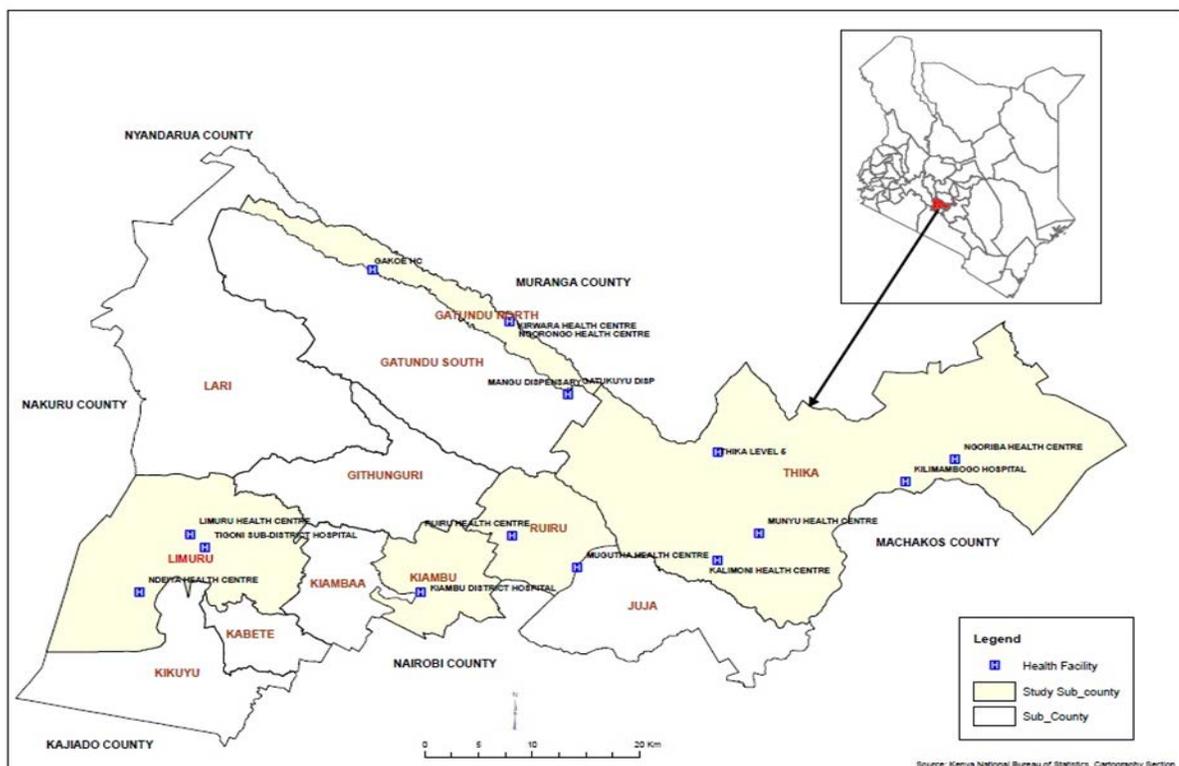
INTRODUCTION

International development platforms and commitments like the Cairo convection of 1994 expressed the need for male partner participation in maternal and child wellbeing programmes [34]. Since these conferences, there has been a formal recognition that more equitable relations between male and female partner are important in achieving international, national or even regional goals on maternal and child wellbeing [32]. Many factors may be implied for male partner's low level of participation in maternal and child wellbeing programmes some of which are barriers existing at societal level referred to as socio-cultural factors [37]. Male involvement in these programmes during pregnancy and post-partum periods has shown greater benefits in maternal and infant outcomes [35,36]. In most patriarchal societies men's main responsibility is perceived as that of providing for the family and in so doing they influence consumption of health services. In most of these societies' men's control over family finances, family mobility and health care decisions impact on the female partner's behaviour in relation to consumption of the services [8, 4]. Men in such societies are expected to be the source of information and decision making a factor that make them feel over ruled by the females who bring home health care information either from the health facilities [9, 7, 30, 13]. Earlier studies have shown that involvement of male-partners in antenatal VCT was associated with increased uptake of the services by their female partners and the infants as well as improved sharing of information between the couple [3, 6, 20, 2]. Male partners' 'infidelity in marriage discouraged them from attending VCT with their female partners in fear of receiving HIV positive results in their presence which would undermine their dominion in the family [1,23]. In most of these patriarchal societies men are not expected to give much information to their female partners a factor that discouraged couple sharing [5,18,10,17,19]. In most of these cultures men and women do not fully express themselves emotionally to each other and this is a barrier to dual participation in maternal programmes and reduced chances of support from the male-partner [28,32, 14]. The area of maternal and child well-being is also perceived as a woman's domain and therefore it is shameful for men to be found at health facilities with women [5,2,33,36]. Such men are deemed weak and that they are controlled by their female partners a factor that discouraged them from participating in the programmes[11,24,31]. The need to seek male-partners' consent for HIV testing and fear of violence in case they tested HIV positive barred female partners from involving the male-partners in the couple CVT

programmes[15,12,1,16]. Male involvement has been found to lead to increased uptake of reproductive health services by their female partners and infants which is evidenced in reduction of maternal and infant morbidity and mortality rates [21,22,25].Lack of support for the female partner becomes a drawback to enrollment into the programmes and even leads to drop out of the less vigorous traumatized females especially in developing countries most of which are in sub-Saharan Africa [34,26,27,29,].This is in turn associated with high maternal and infant morbidity and mortality rates in these countries. For example in 2015 about 303 000 women globally died of pregnancy or childbirth-related complications most of which were associated with lack of consumption of the recommended reproductive health services [36]. The WHO report that at a global level, under-five mortality was 5.9 million while 45% of under-5 deaths occur in their first 28 days of life [36]. Most of these high rates are implied on low or total non-consumption of the maternal and infant health services resulting from lack of support by their male partners [36]. Maternal mortality rates in developing countries are rated at 239/100,000 live births [32]. Kenya is ranked 39th in the <5 deaths globally [36]. In Kiambu County where the study was carried out, low (3%) male-partner participation in the maternal and child wellbeing programmes was identified as a challenge to successful implementation of the programmes. The study sought to determine influence of community related factors and effects of the social environment within which the males were expected to participate in the programmes.

METHODOLOGY

The study adopted an analytical cross-sectional design. The study was carried out in Kiambu County, Kenya to determine if there existed a significant relationship between cultural factors and male-partners' level of participation in MCW programmes in Kiambu County, Kenya. Kiambu County's strategic plan 2013 had reported a low (3%) level of male partner participation in maternal and child well-being programmes was implied as a drawback to successful implementation of the programmes in the County. No earlier study had been carried to determine the factors that could be responsible for the low participation. This study was therefore carried to



determine if there existed a significant relationship between male partner level of participation in the programmes and the community's cultural values. The researcher picked mothers systematically as they reported to level four and five health facilities to consume the MCW services in the County and their consent was sought. Consenting mothers were requested to introduce their male partners to the study. The male partners' consent was also sought. Consenting male partners formed the study respondents from who the primary data were collected. Secondary data were collected from earlier studies and it informed the background to the study. The study involved collection of quantitative as well as qualitative data. The collected data were analysed with aid of SPSS. Data was subjected to descriptive statistical as well as inferential analysis. The findings from the analysis were presented in frequencies, percentages, histograms and tables.

Figure 1. Map of the study area within the inset map of Kenya

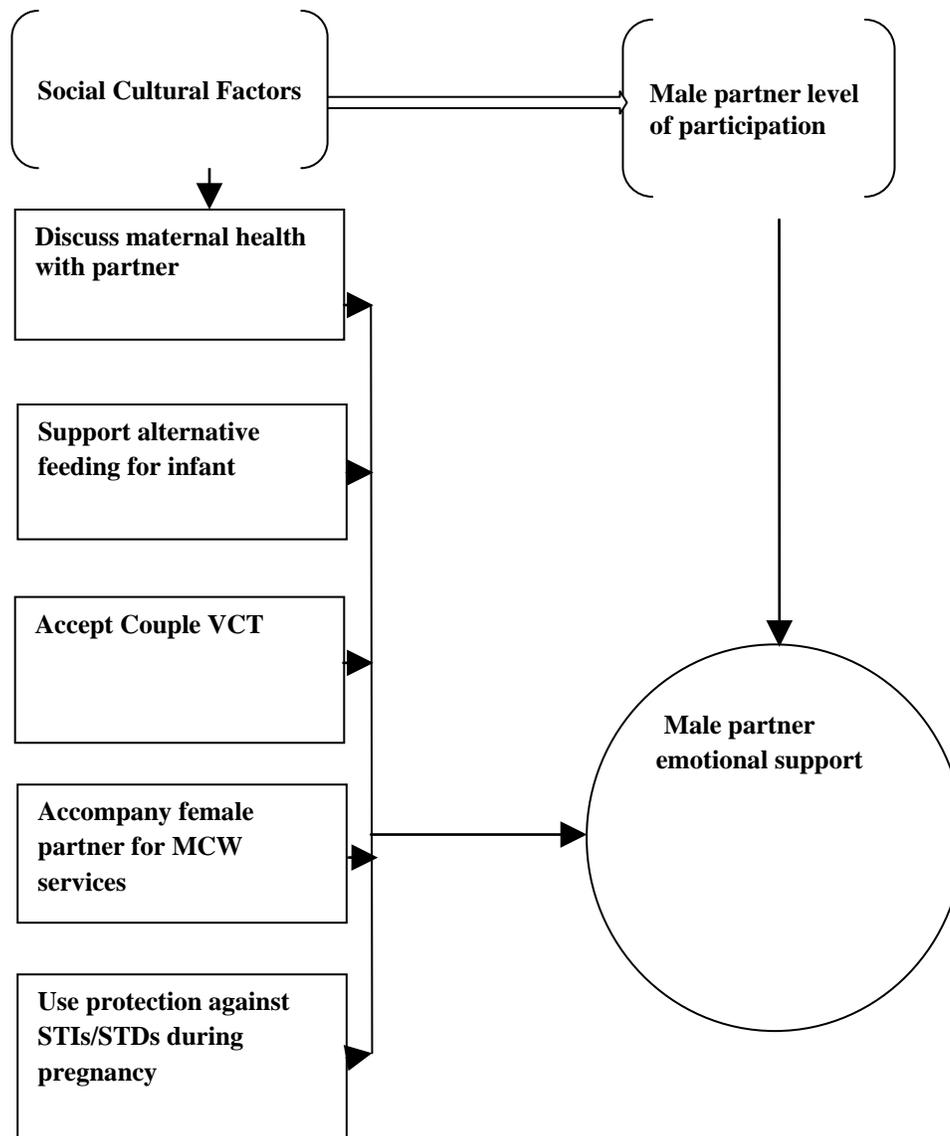


Figure 2. The Conceptual framework

STUDY FINDINGS

The study findings revealed that cultural factors were significant determinants of male-partner's level of participation in maternal and child well-being programmes in Kiambu County, Kenya. Chi-square test was used to test for independence of the outcome variable (male partner level of participation in maternal and infant well-being programmes in the County) and the predictor variables (the community based cultural values). The key predictor variables included effects of male partners' cultural values and beliefs based on their perception towards male partners who participated in various programmes. The Chi-square test revealed a value of 137.106, at df-1 and p value of 0.000 meaning the community's perception had a significant negative effect on level of participation. Male partners who perceived it as a taboo to discuss reproductive health issues with their pregnant partner recorded a significant low level of participation as revealed by a Chi-square value of 40.914 at df-1 and a p value of 0.000. The effects of male partner perception towards couple VCT was found to have a significant negative effect as revealed by a Chi-square value of 46.396 at df-1 and a p value of 0.000. The study also sought to establish effects of male partners' perception that male partners should use preventive measures to prevent secondary sexual infections during pregnancy which was found to be significant at a Chi-square value of 7.122 at df-1 and a p value of 0.008. The study further established that male perception that maternal clinics are designed for women and children only had a significant negative effect at a Chi-square value of 14.547 at df-1 and a p value of 0.000. Logistic regression test for the relationship between dependent and independent variables revealed that, $y = (\alpha) 0.700 +$ effects of cultural factors (-0.229). Based on the study findings therefore, cultural factors are significant determinants of male-partners' level of participation in maternal and child well-being programmes in Kiambu County. The Cox and Snell R square and Nagelkerke R square of 0.607 and 0.819 (Table. 1) revealed that the model of goodness of fit is satisfactory and that social cultural factors explained 81.9% (Nagelkerke R²-Table 1) of the variation in male partners' levels of participation in the programmes while Cox and Snell R square show that the cultural factors explain 60.7% of the variations in the level of participation.

Table 1. Goodness of fit model for cultural factors

odds Summary	
-2 Log likelihood	59.325
Cox & Snell R Square	0.607
Nagelkerke R Square	0.819

The Exp (B) column (the Odds Ratio) (Table. 2) show that male-partners who felt that discussing reproductive health issues with pregnant partner was a taboo were 10.166 times less likely to register a high level of participation in the programmes compared to those who never perceived it a taboo. Male-partners who perceived the MCW programmes as designed and meant for women and children only were 6.050 times less likely to register a high level of participation compared to those who believed male-partner could participate. Further, the Exp (B) column (the Odds Ratio) shows that male-partners who believed that MCW programmes' information should be communicated to the family through the family heads (male-partners) were 1.937 times less likely to register high level of participation compared to those who thought the information could be channeled through the female or the male-partners. The study findings revealed a significant negative relationship between the community's cultural values and beliefs. This was explained by the fact that a community' values and beliefs shape peoples' perceptions and influence their behaviour.

Table 2. Logistic regression analysis for effects of cultural factors on male-partners' level of participation

	B	S.E.	Wald	df	Sig.	Exp(B)	1/Exp(B)
Tested without approval(1)	0.159	0.078	4.155	1	0.042	1.172	
Accompany partner(1)	1.079	0.461	5.478	1	0.019	2.942	
Men are bewitched(1)	1.752	0.45	15.158	1	0.000	5.766	
Taboo to discuss(1)	-2.319	0.912	6.466	1	0.011	0.098	10.166
Couple testing(1)	1.312	0.53	6.128	1	0.013	3.714	
Use of condoms(1)	0.29	0.097	8.938	1	0.003	1.336	
MCW for women children (1)	-1.8	0.645	7.788	1	0.005	0.165	6.050
Unfaithfulness(1)	-1.501	0.974	2.375	1	0.123	0.223	4.486

Infected women be divorced(1)	-0.135	0.704	0.037	1	0.848	0.874	1.145
Information through men(1)	-0.661	0.803	0.678	1	0.41	0.516	1.937
Constant	-1.937	1.87	1.073	1	0.3	0.144	6.938

DISCUSSION OF THE FINDINGS

Male partners' behaviour in relation to reproductive health are outcomes of factors existing at the societal level and which guide gender relations and division of labour. The study realised that the most pertinent was the societal perception that the field of maternal and child health was a woman's domain and male partners needed to give women a chance to pursue issues that are socially theirs. Majority of the respondents did not agree that women can be tested for HIV without their male-partners' consent. The study found that respondents who had the perception that women cannot be tested for HIV without their male-partners' consent were less likely to register a high level of participation as compared to those who did not. Majority of the respondents did not agree that male partners should accompany their female partners to the health facilities for MCW programmes. These respondents registered a low level of participation in the programmes. There was ridicule to men who physically accompanied their female partner to the health facility because they were perceived to be weak. This perception discouraged other male partners. For example a respondent from Ruiru sub-County in the Kiambu County commented: *"It is our way of life inherited from our ancestors. There are duties for women and men. If my friend sees me take my wife to the clinic they will say 'huyu amekaliwa' (this one is henpecked). If they did not believe in the culture, they wouldn't burst me, but right now if I also see a man take his wife to clinic when pregnant I will tell him 'bwana umekaliwa na bibi nyumbani'.* Another respondent from Gatundu sub-County reported; *you know according to our way of life, men are taken as kings, so if you're seen carrying a baby, you are seen to be 'voiceless'. Also, if you are so much concerned with women, they'll see you to be voiceless (Mister, your wife controls you at home)".*

Culture coupled with peer pressure played a major role in determining male partners' level of participation in maternal and child wellbeing programmes due to negative perceptions towards some MCW programmes. For example, the study found that majority of the male partners was not in support of some MCW programmes such as condom use during pregnancy and alternative feeding for infants. Majority of the respondents believed that it is a taboo to discuss reproductive health issues with the female partner during pregnancy as this would cause misfortune. Respondents who had the perception that discussing MCW issues with their pregnant female partner was a taboo registered a lower level of participation. Despite the challenges brought about by the prevailing cultural beliefs in Kiambu community majority of the respondents agreed that there are more benefits if male partners became more responsive in matters concerning their own reproductive health and that of their female partner. Among these benefits are increased understanding of pregnancy and related issues, enhanced levels of preparedness from the time the female partner is pregnant until she delivers and after delivery during breastfeeding. The study revealed that male partners are very willing to support the health of their female partner and that of their children. Some men are even willing to denounce customs and practices that challenge the women's health and that of their children. The study further noted that perception of male partners as intruders into the women's reproductive domain led to their failure in participating in couple VCT a challenge in dealing with couple discordance in HIV sero-status.

The study found out that most obstacles to involving male partner in maternal and child wellbeing programmes revolve around socio-cultural factors such as men's fear of losing control of their position as family heads. The study found that deep-rooted cultural norms about gender roles and power hierarchy are major obstacles to male participation in the maternal and child wellbeing programmes. Women's efforts to overcome these challenges have remained a huge challenge over decades because power of decision making lies with the male partner as the family head. Male partners were not supportive of programmes where the female partner made decisions regarding maternal and child health without their male-partners' consent. For example, men did not like invitations to the health facility by their female partner because this meant they are the ones making decisions and controlling the male partner. The findings revealed that for most respondents, physical participation in maternal and child wellbeing programmes implied weakness. They also fear that accompanying their female partner to the maternal and child wellbeing facility would increase their vulnerability and expose any reproductive health secrets, exposures that could reduce their social status. The study also found that women did not have the authority to request their husbands to test for HIV which made it difficult to involve male partner in VCT through their female partner. Most respondents explained that HIV testing is an important part of preparing for fatherhoods however receiving a positive HIV result in the presence of their female partner discouraged male partners from attending VCT with their female partners. This would mean they lose their confidentiality as well as their status as family head. These findings revealed a strong correlation between male partner's perception towards the programmes as influenced by cultural beliefs and their effect on level of participation.

SUMMARY OF THE FINDINGS

The study concludes that Kiambu community's established cultural norms that define the expected male and female behaviour in relation to reproduction were significant determinants of male-partner's level participation in maternal and child well-being programmes. Respondents who were more conservative of the community's cultural norms registered a lower level of participation in the programmes compared to those who were liberal. This study concludes that the relationship between cultural factors and male-partners' level of participation in maternal and child well-being programmes is significant and negative.

RECOMMENDATIONS OF THE STUDY

The study points out that it is important for the County government of Kiambu to incorporate the community's cultural values during policy formulation as well as implementation. This may help break the cultural barriers to male-partner participation with an aim of limiting them. In this regard, overturning the attitude that maternal and child well-being programmes is a woman's responsibility could improve male-partner's participation. The County government should determine male-partners' priority goals, routes of action, as well as culturally appropriate strategies that can create positive impact. Priorities in reproductive healthcare provision should be locally identified in accordance to the male-partners' most pressing needs. There is need to carefully consider the community's acceptability of any intended health promotion interventions before their implementation to increase acceptability. Suitable community specific channels such as peer educators and men leaders may be trained and supported to work with professional healthcare providers in different phases of the programmes.

There is need to carefully consider effectiveness and acceptability of any intended health promotion interventions by the intended consumers before implementation to increase their effectiveness. There is need for healthcare system amendments and context-specific adaptations of public policy on maternal and child well-being services to break down barriers and facilitate participation. Well targeted and focused male participation programmes may have positive influence on their level of participation and promote reproductive well-being. There is need to carry out research on participatory approach that integrates male issues in on-going as well as future maternal and child well-being programmes. Relevant authorities should support this fact finding about MCW programmes related short-comings and existing cultural conditions that relate to male participation as a first step in operational research. This research should support the testing of different participatory approaches to promotion of the acceptable ones by specific communities. It should also assess the impact of specific programmes such as male or female-specific clinics, offering of VCT services for men at antenatal clinics, options for both couple and individual counseling and testing, among others.

There is need to implement such findings in favour of male-partner participation in the programmes throughout their life cycle.

The study recommends adoption of culture-sensitive strategies that address maternal and child well-being needs of the community in which they are applied. This is may increase acceptability of the programmes by male gender leading to their increased participation. For example, healthcare providers and policy makers need to understand how men relate to women in the field of reproduction and as well as factors upon which men make decisions in reproductive issues. This mean that the County government and the National government should establish the best culture specific action plans that can be adapted in men dominant societies to promote their involvement in maternal and child well-being programmes.

APPENDIX

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