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SOCIO-CULTURAL CHARACTERISTICS ON MALE INVOLVEMENT IN SAFE MOTHERHOOD AMONG COMMUNITIES IN KWALE AND KILIFI IN COASTAL KENYA

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Abstract

Purpose: The main purpose of this study was to establish the effect of social cultural characteristics influencing male involvement in safe motherhood among communities of Kwale and Kilifi Counties of Coastal Kenya.

Methodology: The study was descriptive cross sectional design. The study focused on women of child-bearing age 15 – 49 and men aged 15 – 54 from Kilifi and Kwale counties in 14 health facilities. Qualitative and quantitative methods of data collection were used. Interviewer-administered questionnaire were administered to women who were attending ANC. Data was also collected using semi-structured interviews with health service providers, community leaders and county directors. Focus group discussions were conducted using FGD guide with four women and men groups. Analysis was done using SPSS and NVivo softwares.

Results: The findings also revealed that the role of cultural beliefs and taboos associated with male involvement in safe motherhood highly featured in all the interviews and FGDs and were highlighted by all respondents.

Unique contribution to theory, practice and policy: The study recommends that to influence cultural facades, Kaya elders should be used to mobilize and provide leadership in health will free men of negative attitudes. Recognize men and prioritize services and youth friendly services to support men. Support Men to understand the importance of their role and protecting girl child and teenage pregnancy

Keywords: *Social Cultural, Safe Motherhood Practices, Male Involvement*

1.0 INTRODUCTION

1.1 Background of the Study

Men do not seek health information and services due to traditional notions of masculinity, where asking for help from a nurse or doctor is viewed as a sign of weakness. Many men feel it is their right to refuse contraception, to allow their partners or even discuss FP (Engender Health, 2008). These refusals can lead to unwanted pregnancies, unsafe abortion and maternal death or disability. Reporting their findings from the study on women's autonomy and male involvement in Nepal, Britta at el, concluded that higher women autonomy was associated with lower male involvement in pregnancy health. Barriers to male participation include the perception of family planning and reproductive health as concerns of women maternal-child health services that do not target men, the limited availability of male contraceptive methods, and societal attitudes unfavorable to explicit support for equality of men and women (Ormel, 1997).

Communication problems between men and women are certainly a significant social barrier as well. A theme that emerged repeatedly is that use or even discussion of FP may be interpreted as a sign of unfaithfulness or lack of commitment to the marriage. There was clear evidence among the focus groups that there was distrust of women's fidelity. Some men think that if they use FP their women will become promiscuous. This partly stems from failure to involve both partners as a couple right from the beginning of using family planning. The program should aim at counseling both parties together if possible. The degree and quality of spousal communication must be improved for the good of the family planning program.

Men do not seek health information and services due to traditional notions of masculinity, where asking for help from a health provider is viewed as a sign of weakness. It is not uncommon in most African societies for men to decide as to when and how a woman should seek care. For example a study done in Kano Nigeria, shows that 17.2% women did not attend regular ANC because of husband denial (Adamu & Salihu, 2002). In Uganda, despite health facilities being in walk able distances in many districts, women having income and improvement in the quality of care, women continue to report late for ANC and deliver outside the health facilities (Kasolo & Ampaire, 2000).This fact of male's affecting utilization of ANC and PNC services in Uganda is supported by the findings of the study done by Nyane (2007) in Toronto in which she observed that some pregnant women when asked to come with their partners during the next ANC visit dropped out. A study done among Garo people of India revealed that cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities (Nyamongo, 2003).

Mkandawire and Hendriks (2018) researched on Men's involvement in maternal and child health presents an opportunity for the advancement of maternal and child nutrition as men often play a key role in decision-making particularly regarding women's reproductive health. While most research on men's involvement in maternal and child health has focused on men's participation in antenatal care, this study focuses specifically on men's involvement in maternal and child nutrition. The authors identified several factors that facilitate men's involvement in maternal and child health, but we also identified several barriers. Facilitators of men's involvement included: recognition by men of the impact of their involvement, pride, advocacy, incentives and disincentives and male champions. Barriers included socio-cultural beliefs, stigmatization and

opportunity costs. The study also found that there were several limitations that had unintended consequences on desired programme outcomes. These included: discriminating against women, marginalization of married women and reinforcing men's decision-making roles.

Lowe (2018) conducted a study on Social and cultural barriers to husbands' involvement in maternal health in rural Gambia. The author found out that rural Gambian men and traditional birth attendants (TBAs) reported that husbands' involvement in maternal health is highly desirable but is influenced by many factors, such as the traditional conceptualization associated with pregnancy and delivery as women's domain. In addition, many men do not believe that pregnancy chores warrant their efforts compared to other competing social responsibilities. This issue may be more complicated in polygamous marriages where there is rivalry among co-wives and in neighborhoods where men who help with house chores may be subjected to mockery. The study concluded that husbands' involvement in maternal health in The Gambia is influenced by the prevailing social and cultural practices of gender role and norms, which are also at the root of maternal health problems.

Byamugisha *et al.* (2010) asserted that cultural standards were identified as barriers for male involvement. Several studies have reported negative perceptions towards men attending ANC services. In one report, men who accompanied their wives to ANC services were perceived as being dominated by their wives or weaklings by their peers. Frequently men perceive that ANC services are designed and reserved for women, thus are embarrassed to find themselves in such "female" places. Some men believe it is not good to follow your wife to the antenatal clinic even though she exposed her privacy to you at home and that male participation in ANC services is superfluous and that ANC is "a woman's responsibility" Certain women too, do not like to be seen with their male partner attending the ANC service. A study conducted in Kenya showed that certain male clients trust traditional healers but not hospitals and therefore do not attend ANC clinics.

Traditional community perceptions have been reported as inhibiting male participation in antenatal care. Most men perceive antenatal care as a woman's affair and men seen going with their wives to antenatal clinics are perceived to be a weaklings or being jealous (Byamugishya et al., 2010). Culturally men are not allowed to get involved in women health issues, more especially in antenatal clinics and labour wards as these areas are culturally perceived as places for women. Similar findings were reported by Homsy *et al* and Msuya *et al* who reported that it is culturally a taboo and shameful for a man to be found where women go to give birth (Homsy *et al*., 2006; Msuya *et al*., 2008).

1.2 Problem statement

Male involvement is often and traditionally poorly understood and too narrowly defined. Minimal attention has been given to their important role in decision-making within the family and community context. Barriers such as low levels of education, the lack of available social support, the perception that pregnancy and child-bearing are "women's responsibilities", and prevailing gender norms and societal stigma persist. Moreover, the concept of male involvement cannot be viewed only through the lens of sexual and reproductive health; it must extend to the broader context – including economic empowerment, financial decision-making within the household, nutrition to education.

The role played by men and their relationship with women in reproductive health has been appreciated by many and even documented. There is absolutely little excuse for overlooking men in this regard. Ten years ago, the 1994 United Nations International Conference on Population and Development (ICPD) stressed "male responsibilities and participation" in sexual and reproductive health. In fact Dudgeon *et al*. confirms that for several decades, medical anthropologists have conducted reproductive health research that explores male partners' effects on women's health and the health of children.

Although there are more considerations for male involvement strategies in the current programming in sub Saharan Africa, the lack of data on successes has limited the replication and further investment in this intervention. In a documentary by FAO, the technical o*ccasional* Paper Series No. 1 June 1998, sites the lack of data to understand male perspectives and the extent of their involvement in reproductive health issues as a major setback. It presupposes that the surveys most relied upon for reproductive health (RH) programmes usually ask questions only of women, assuming that they are the ones who make the decisions regarding reproduction and that the men are either not involved or marginally involved. This is why this study will deliberately target men in male unions and groups to try and provide opportunity of fair participation.

Men are traditionally the decision-makers within Kenyan households, and women's access to and use of sexual and reproductive health services often depends upon their partner's knowledge and decisions. Commonly referred to as *"mwenye syndrome"* in the coastal region meaning men own women and hence all the decisions depend on them including accessing safe motherhood services. Men play crucial role in contraceptive decision-making, particularly in highly gender-stratified populations like in the coastal region.

Research suggests that male involvement can increase uptake and continuation of family planning methods and by extension safe motherhood services by improving spousal communication (Awah 2002**)** through pathways of increased knowledge or decreased male opposition. The need to understand barriers to male involvement and participation and whether there are any association with access to services and health seeking behaviors towards safe motherhood is crucial. This study will therefore determine the factors that influence male involvement in safe motherhood among communities in Kwale and Kilifi counties of coastal Kenya.

2.0 METHODOLOGY

The study was carried out in two counties; Kilifi and Kwale counties of coastal Kenya. The populations in these counties are primarily with low levels of education and poor, hence compromising their health service utilization. The study was descriptive cross sectional. The study focused on women of child-bearing age 15 – 49 and men aged 15 – 54 from Kilifi and Kwale counties in 14 health facilities. Specifically the study conveniently recruited 22 male of 18 years of age and above, and 66 pregnant women and mothers 18 years or older attending ANC and were either accompanied by their partners, had delivered at the hospital or attending postnatal care services, and had cconsented to participate. Qualitative and quantitative methods of data collection were used. Interviewer-administered questionnaire were administered to

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women who were attending ANC. Data was also collected using semi-structured interviews with health service providers, community leaders and county directors. Focus group discussions were conducted using FGD guide with four women and men groups. Analysis was done using SPSS and NVivo softwares.

3.0 RESULTS FINDINGS

3.1 Socio-cultural characteristics of male partners influencing male involvement to health facilities for Safe Motherhood.

The role of men however was not limited to giving permission to attend ANC but also provided the resources to attend ANC. 172 (46.2%) of women who attended ANC were spouses of husbands who engaged in piecework as livelihood activity. Generally 93.5% of women who attended ANC had their husbands engage in either business, piecework, farming, office work and any other form of livelihood activities.

Table 1: Husband's Livelihood * Attendance to Antenatal care-previous pregnancy

		Attendance to Antenatal care-previous pregnancy		
		Yes	No	Total
Husband's Livelihood	Business	78	6	84
	Piece work	172	12	184
	Office work	59	5	64
	Farming	28	0	28
	5	11	1	12
Total		348	24	372

There was a clear indication that most women had to obtain authority to access health care. This is evident by over 90% of women seeking permission. Experienced mothers in the village were trusted to give advice to the new ones especially when it came to attending ANC. This is confirmed by a higher proportion (14.9%) of women seeking advice to attend ANC from other people compared to mother (6.4%), mother in law (1.8%) and boyfriend (1.0%). Interestingly 79.7% of women interviewed were pregnant because they wanted to have a child and were in recognized marriage relationships indicating men involvement begins with the discussion to have a baby. This is compared to 18.4% of women who accidently got pregnant and 1.5% who were forced by their husbands to get pregnant. Majority 317 (81%) of the married women who sort permission from their husbands, 79.5% attended antenatal care in previous pregnancy.

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Table 2: Permission for Antenatal clinic attendance verses attendance to Antenatal care in previous pregnancy

			Attendance to Antenatal care-previous pregnancy		
			Yes	No	Total
Permission for Antenatal clinic attendance	Yes	Count	311	6	317
		% of Total	79.5%	1.5%	81.1%
	No	Count	52	22	74
		% of Total	13.3%	5.6%	18.9%
Total		Count	363	28	391
		% of Total	92.8%	7.2%	100.0%

Most men 293 (73.8%) were the bread winners of their families and the permission to go to attend antenatal clinic was sort from them. Majority of Husbands 295 (75.9) were the first to be told about pregnancy especially among the Digo (32.6%) community. The Durumas' had a high interest in where the children were to be delivered while other tribes discussed a lot on the preparation for the baby. The traditions surrounding pregnancy did not feature explicitly in spousal discussion even though it was expected to form a major part. Maternal nutrition however was the least discussed despite its correlation with pregnancy outcome.

There was a great deal of what spouse discussed according to age. For instance those between ages of 15-20 were majorly concerned with preparation for the baby, ages 21-25 were majorly discussing where to attend ANC and preparation for the baby. It was clear from the data that ages 36 – 45 years did not discuss maternal nutrition at all. These discussions were based on what roles to play during the pregnancy until delivery.

> *"Men and women play different roles in the family and pregnancy is for women. Alcoholism (Mnazi) takes men's free time. A lot of decisions are based on culture including how many babies. Men wait for babies"* (Respondent in male union in Kilifi)

4.0 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.1 Summary of Findings

The findings also revealed that the role of cultural beliefs and taboos associated with male involvement in safe motherhood highly featured in all the interviews and FGDs and were highlighted by all respondents. According to this study, women were to be accompanied by those assigned to them by their men, '*Mwenye syndrome*' where women do not make any decisions while on the other hand alcoholism (high consumption of palm wine popularly known as *Mnazi*) took a lot of men's time. Also, a lot of misconception about gender roles outlining different roles during safe motherhood existed and the fact that most decisions were anchored on traditions. Muslim women for instance were not even allowed to shake hands with men and that men were

not supposed to see half naked women and interact with other women. Men did not know they were to accompany their wives to the hospital during pregnancy. The findings agree with those in Byamugishya *et al*., (2010) who asserted that Traditional community perceptions have been reported as inhibiting male participation in antenatal care. Most men perceive antenatal care as a woman's affair and men seen going with their wives to antenatal clinics are perceived to be a weaklings or being jealous (Byamugishya *et al*., 2010). Culturally men are not allowed to get involved in women health issues, more especially in antenatal clinics and labour wards as these areas are culturally perceived as places for women. Similar findings were reported by Homsy et al and Msuya *et al* who reported that it is culturally a taboo and shameful for a man to be found where women go to give birth (Homsy *et al*., 2006; Msuya *et al*., 2008).

4.2 Conclusion

The study sites are highly ethicized by the Durumas a fact that explains the deep rooted cultural practices and Islamic subscription. The study also concluded that there were strong male cultural perception related to safe motherhood especially that pregnancy is a "woman's affair" and a naturally prescribed stage that a woman has to go through and does not warrant them being involved.

4.3 Recommendations of the Study

The study recommends that to influence cultural facades, Kaya elders should be used to mobilize and provide leadership in health will free men of negative attitudes. Recognize men and prioritize services and youth friendly services to support men. Support Men to understand the importance of their role and protecting girl child and teenage pregnancy.

Declarations

Ethics approval and consent to participate

Ethical approval was sort by the researcher and provided by Pwani University Ethics Review Committee (REFERENCE NO: ERC/MSc/040/2014) (Annex 5) and additional formal permissions obtained from the office of the Chief Officer of health Kwale county Ref no: CG/KWL/6/5/1//COH/44/12 (Annex 3) and Director of Health Kilifi County. Further, the researcher obtained authorization and ethical approval from the study supervisor and the local Research Ethics Coordinator of the academic unit at the university. To gain access to the participants and study approval, both local and national permission were sought formally and received from the County and Sub County Health Management Team. Further, the Community Strategy technical support staff from DSW project working in the county were contacted to link the researcher with the target participants as they closely work with them.

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