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# Cultural Factors as Determinants of Male Partner Involvement in Antenatal Care in Kiambu County, Kenya.

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In spite of the call to involve male partners in antenatal care, their involvement is still low in low and middle level countries. Previous research has demonstrated that male partner involvement is very vital in the optimization of antenatal care services and leads to better maternal neonatal health outcome. This study explored the effects of cultural factors in male partner involvement in antenatal care in Kamenu Ward, Kiambu County. It looked into the effects of cultural factors such as cultural beliefs, taboos and segregated gender roles on male partner involvement in antenatal care. The study utilized a descriptive cross-sectional survey design providing both quantitative and qualitative data. It used Self-administered questionnaire and collect data from 384 male partners aged 18 – 90. The results found that cultural factors had significant positive relationship with male involvement in ANC, and it could be concluded that cultural factors such as segregated roles, cultural beliefs and taboos determined whether a male partner would get involved in her spouse ANC or not. The researcher recommends that County government through the health community strategy initiative, and partnering with religious and the community leaders to avert the negative cultural influence through health education.

**Keywords:** male partner involvement, utilization, antenatal care

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## I. INTRODUCTION

Male partner involvement is referred as male partners actively participating in protecting, promoting the health and wellbeing of their spouses and children which is realized when male partners support decisions and activities that improve maternal health (Yargawa & Bee, 2015). It improves maternal neonatal health; increases couple communication, improves relationships, reduces maternal workload and improves maternal nutrition and rest during pregnancy (Asefa, et al., 2014; WHO, 2015). In addition, Early male partner involvement offers them an opportunity to participate in their spouses and child's care and provide physical and emotional support during and after pregnancy (Well, et al., 2015).

In this regard, it is currently being promoted and adopted globally, nationally and at sub-national level through policy and program planning as a promising strategy to improve MNH **(**Thomson, *et al.,* 2015). However, male partner involvement in utilization of maternal child health services has been challenging worldwide (Kumbeni, *et al*., 2019).

Male partners can positively influence MCH in a variety of ways, therefore, when informed can make sound decisions on behalf of the family for better health (Akinpelu & Oluwaseyi, 2014). They can encourage their pregnant spouses to attend ANC, accompany them, help prepare and save money for delivery, and arrange transportation to the birthing center, among other responsibilities (Sigh, et al., 2014). In addition, male partner involvement in MNCH promotes good nutrition, reduces workload during pregnancy, assists with birth preparations, provides emotional support, contributes towards creating a gender equitable family environment, assists in household chores, supports equal access to health services to all children, improves couple communication and reduce violence (Thomson, et al., 2015; Akinpelu & Oluwaseyi, 2014).

Regardless of the presence of the supportive policy for male partner involvement in ANC, they still have challenges in getting involved during prenatal period and childbirth (Kakaire, et al., 2014). According to Doe (2013) Cultural beliefs, taboos and segregated gender roles play a major role in male partner involvement during pregnancy (Doe, 2013).

Globally antenatal care has been perceived as a woman's affair hence it has been shameful for male partners to be seen in antenatal clinic (Morfaw, et al., 2013).

He further reviewed that, according to the culture male partners were not supposed to participate in antenatal care activities and the society ridiculed those who accompanied their pregnant spouses to ANC. Traditionally, in East New Britain male partners are excluded from ANC, those who attend are embarrassed and ashamed. According to their culture, male partners are not supposed to move around with their pregnant spouses for this will force village elders to be harsh on them (Holmes, et al., 2012). In India male partners who accompanied their pregnant spouses to ANC did not enter the examination room but remained outside due to their negative culture influence (Varkey, et al., 2004).

In Africa, pregnancy matters are perceived as a woman's affair that does not need male partner's presence (Kululanga, et al., 2011; Kakaire, et al., 2011). In South Africa, male partners did not enter the ANC examination room but remained outside due to their negative culture influence (Mullick, et al., 2005). Male partners in Malawi, Cameroon and Uganda were ridiculed by their peers because of accompanying their pregnant wives to ANC (Morfaw, et al., 2013). He further stated that, male partners are seen as being jealous, over-protective of their wives and lacking self-confidence and some communities condemn those attempting to get involved in their wives pregnancy issues.

Nkuoh, et al. (2010) identified a cultural communication among men and women where they never fully express themselves. In this cultural communication, men keep silent and women never complain. These patterns of cultural communication hinder dialogue among couples limiting male partners' involvement in PMTCT as part of ANC services. In South Africa, women do not discuss with their partners maternal issues due to negative cultural influence (USAID, 2010).

In East Africa, Studies in both Tanzania and Uganda demonstrated that, male partners perceive ANC as a woman's affair and men were ashamed of accompanying their pregnant spouses (Morfaw, et al., 2013; Theuring, et al., 2009). Male partners in Uganda were ridiculed by their peers because of accompanying their pregnant wives to ANC (Morfaw, et al., 2013). In Kenya, pregnancy and childbirth has been exclusively regarded as women's affair and men generally do not accompany their partners to antenatal clinic due to poor cultural practices resulting to underutilization of antenatal services (Akinpelu & Oluwaseyi, 2014).

A Study in Mavoko Machakos revealed that cultural beliefs and men's superiority complex and perception that their dignity and self-esteem would be disregarded if seen in the antenatal clinic (Kidero, 2014). A study in Busia by Nanjala and Wamalwa (2012) demonstrated that, negative cultural practices of male partners affects their participation greatly where almost half of the men (48.2%) said they would be ridiculed by their peers, relatives and perceived as being ruled by their wives if they were seen accompanying their wives to a health facility.

Greene et al. (2004) has stated that both developed and developing countries have been slow in supporting male partners' roles in the family until recently. Worldwide, in most of the communities men are the decision-makers within families and hence play a key role in decisions pertaining to MNCH (Thomson et al., 2015). In Nicaragua Latin America, cultural issues such as gender norms hinder women's access to health care.

According to their culture, men control household resources and are not supposed to seek care for their wives and children, especially during pregnancy, childbirth, and the postpartum period (USAID, 2014).

USAID (2014) further stated that women have no authority to make decisions and this limits them from accessing household financial resources and to seek health care in a timely manner. In London, culture has a bearing on decision making regarding pregnancy and childbirth (Nessie & Oluseyi, 2013). Varkey et al. (2004) have stated that, women rely heavily on their male partners to access healthcare in India and they are the key decision makers for their partners' choice of health care services although they lack adequate knowledge.

Morfaw, et al. (2013) found that, in most African cultures women are not supposed to lead and not allowed to instruct their male partners on what to do hence closed out from joint decisions on matters concerning antenatal care services. In addition, men and women are assigned different gender roles in the family and community (Asefa, et al., 2014). Men are the decision makers in the family setting including pregnancy issues, delivery, child health hence promoting and preserving the life and future of the family (Akinpelu & Oluwaseyi, 2014). In addition, Bhatt (2013) has argued that men are not only decision-makers for women and children's access to health services, but an abuse or neglect act can directly affect their female partners and children health.

Yet, policies supporting positive roles for men in their sexual and reproductive lives are neither clear nor specific although they offer promising ideas on how men could be involved more centrally. In addition, gender related policies do not consider the concept of equality and men's role in promoting women's access to services and development opportunities (Greene, et al., 2004).

In East Africa, a study in Tanzania found that, it is not the role of male partners to accompany their spouses to ANC (Theuring, et al.,2009). In Kenya, pregnancy and child birth is woman's role and men are not supposed to be found in the surroundings.

Men are the head of the families and being seen in the RH clinic or discussing reproductive health issues with their spouses is a demotion of their status (Onyango, et al., 2010).

In East New Britain, male partner's activities could be harmed because of being so concerned with their pregnant spouses. Male partners were also prohibited from having sexual activity with their pregnant spouses hence could be exposed to a promiscuous behavior (Holmes, et al., 2012). In India, it is a taboo to see a baby being born (Varkey, et al., 2004). In Africa, the study in South Africa women argued that male partners will become weak once they see them necked (Mullick, et al., 2005).He further stated that, it was a taboo for a woman to sleep with the husband in the same room before six weeks were over. In contrast, a study in Ghana found out that, there was no taboo associated with male partner involvement in a woman pregnancy period (Doe, 2013). In Kenya, a study in Busia Kenya revealed that women deliver at home because a newborn baby has to remain indoors for three to four days to avoid bad omen and a placenta has to be buried for baby's safety from witchcraft (Nanjala & Wamalwa,2012).

### 1.1. Study Question

What are the cultural factors that influence male partner involvement in antenatal care in Kamenu Ward, Kiambu County?

### 1.2. Study Objective

To establish cultural factors that influence male partner involvement in antenatal care in Kamenu Ward, Kiambu County.

**Null Hypothesis**

There is no Relationship between Cultural Factors and Male partner Involvement in ANC care in Kamenu Ward, Kiambu County.

## II. MATERIALS AND METHODS

The study adopted a descriptive cross-sectional design and provided both quantitative and qualitative data to establish the determinants of male partner involvement in antenatal care in Kamenu Ward, Kiambu County.

The researcher used a self-administered questionnaire and a focused group discussion guide. The questionnaires had both open-ended and closed-ended questions where in each item was addressing a specific objective. Focused group guide was also used to fill the data during focused group discussion.

The collected data was checked for completeness and accuracy. The questionnaires were numbered at the time of storage and kept safely in the sequence of their numbering under key and lock by the principle investigator for the duration of fourteen days of data collection. The information collected was not accessed by people not directly involved in data collection. The raw data was cleaned, systematically organized, edited and coded in a manner that facilitates analysis using statistical package for social science (SPSS) version 23.

Descriptive and inferential statistics were used to analyze various quantitative data. In this study, descriptive statistics included the means, standard deviations and percentages obtained from all the variables. Inferential statistics included the Pearson Correlation analysis denoted by (r).

Correlation analysis was used for purposes of determining whether a statistically significant relationship existed between independent variables (male partner factors and cultural factors) and dependent variable (male partner involvement in ANC) in line with the study hypotheses.

Moreover, the coefficient of determination ($R^2$) was found in order to estimate the change in the dependent variable that is accounted by changes in the independent variables.

### 2.1 Inclusion criteria

the study considered male partners in the age group of 18 - 90 years, whose spouse was either pregnant or had a child aged 3 years or less. In addition, the male partner participants must have been residents of Kamenu Ward.

### 2.2 Inclusion criteria

male partners not within the age group of 18- 90 years or with children older than 3 years or spouse not pregnant were not considered. Moreover, male partners who were not residents of Kamenu Ward and their spouses were pregnant were not considered for inclusion.

**Ethical Clearance**

Ethical clearance was sought from Ethics Review Committee of Mount Kenya University and National Commission of Science, Technology and Innovation (see appendices VII and VIII respectively).

Permission was sought from County Director of Health (CDH) Kiambu County, County Commissioner Kiambu County, the Chief and Sub Chief. Research ethics was observed by ensuring that voluntary informed consent was signed by the participant willingly. Participation was voluntary, the participants had the right to refuse or withdraw from the study with no consequences at any time they wished. They were informed of the importance of the research: that it will identify the gaps in male partner involvement in ANC and inform the policy maker in order to be gender sensitive when planning for MCH services.

The informed consent consisted of the letter of introduction which explained the purpose of the study, the benefit and likely risk to the participant and the participants signed. The information provided was confidential, privacy was provided, the participants remained anonymous throughout the study and care was taken not to disclose their identities. The information was not made available to anybody not directly involved in the study.

The information provided by the participants may be very sensitive to the pregnant women and the community therefore, the researcher sensitized the community leaders, the pregnant women and those with children below three years attending MCH clinic before commencing the study. They were advised that the information gathered from the study will identify the gaps and inform policy makers while planning for MCH services to be gender sensitive. The information generated will benefit the participants, Kamenu Ward community and the society as a whole.

No incentives were given to the respondents as a way of motivating them to participate in the study.

## III. STUDY RESULTS

**Table 1. Respondents' Socio-demographic Characteristics**

| | N | % |
|---|---|---|
| **Age Bracket** | | |
| 18-23 Years | 116 | 30.4 |
| 24-29 Years | 96 | 25.6 |
| 30-35 Years | 71 | 18.6 |
| 36-41 Years | 38 | 10.0 |
| 42-47 Years | 41 | 10.8 |
| 48-53 Years | 6 | 1.6 |
| 54 and Above | 13 | 3.4 |
| **Marital Status** | | |
| Single parents | 21 | 5.5 |
| Married polygamous | 69 | 18.1 |
| Married Monogamous | 283 | 74.3 |
| Divorced | 4 | 1.0 |
| Separated | 4 | 1.0 |
| **Level of Education** | | |
| None | 2 | 0.5 |
| Completed Primary | 77 | 20.2 |
| Secondary | 120 | 31.5 |
| College | 143 | 37.5 |
| University | 39 | 10.2 |
| **Occupation** | | |
| Teacher | 78 | 21.1 |
| Grocery vender | 23 | 6.2 |
| Business | 133 | 36.0 |
| Nurse | 16 | 4.3 |
| Subordinate staff | 47 | 12.7 |
| Doctor | 15 | 4.1 |
| Accountant | 11 | 3.0 |
| Manager | 33 | 8.9 |
| Farmer | 13 | 3.5 |
| **Notes: N = 381** | | |

**Table 1 illustrates the respondents socio-demographic characteristics which included: age, Marital status, Level of education and Occupation**

majority 116(30.4%) were aged 18-23, followed by 96(25.6%) aged 24-29 years, while 71(18.6%) were aged 30-35 years and only 19(5.0%) were 48 years and above.

Regarding marital status, majority of the respondents 283(74.3%) were married in a monogamous family, 69(18.1%) were married in polygamous families, 21(5.5%) were single parents, while 4(1.0%) of respondents were separated and 4(1.0%) completely divorced. In addition, findings in Table 4.1 show that 37.5% had pursued a college level of education, 31.5% had completed secondary school education, 20.2% had primary education and 10.2% with university degrees and only 0.5% had not attended school whatsoever. With regard to occupation, majority 133(36%) were business men, 78(21.1%) teachers, 47(12.7%) subordinate staffs, 33(8.9%) managers, 23(6.2%) grocery venders, 16 (4.3%) nurses, 15(4.1%) doctors and 11(3%) accountants.

**Male Gender Roles**

Table 2 demonstrates the results of the segregated gender roles in the community.

**Table 2. Male Gender Roles**

| Male gender roles | N | Percentage |
|---|---|---|
| Family provider | 293 | 76.9 |
| Decision maker | 296 | 77.7 |
| Head of family | 280 | 73.5 |
| Arrange for transport | 267 | 70.1 |
| Encourage the spouse | 221 | 58.0 |
| Offers financial support | 163 | 45.2 |
| Accompany spouses to ANC | 128 | 33.6 |

One participant reported that:

"*Male partners would be able to pay for any necessities, and importantly, could also prevent their baby from being exchanged during delivery"* (A 28 year old teacher).

Respondents' voices on segregated gender roles could be summarized by two of them who reported that:

*"As a responsible man, it is my duty as a good husband to ensure that I am fully involved in my wife's pregnancy to ensure both her and the unborn child are safe. This I would do by accompanying her for clinics and helping her with household chores, such that at the time of*

*birth, she is not exhausted"* (A father of two in his mid-thirties).

***"When you are with her it shows contact, you are aware of what is going on there and in case of any complications or even if any referral might be needed, you may decide on what you can do…" (***Older male respondent).

**Female Gender Roles**

Table 3 presents results of the analysis of female gender roles.

**Table 3 Female Gender Roles**

| Female gender roles | N | Percentage |
|---|---|---|
| Pregnancy and child birth | 285 | 74.8 |
| House chores | 346 | 90.8 |
| Child's care | 312 | 81.3 |

As presented in Table 3 respondents reported that handling house chores is of one the major roles for their spouses 346(90.8%) in the family followed by child's care 312(81.3%), and pregnancy and child birth 285(74.8%). In addition, respondents also indicated that the perceptions and attitudes of men in the community is that ANC is a female role which would economically deprive day to day life provisions, if male partners were to be actively involved. One participant reported that:

*"According to me, it is not necessary to accompany my wife to the clinic but to facilitate her financially, to cater for medical expenses and other charges"* (30 year old first time father to be).

**Community Taboos**

Results on the analysis of community taboos are presented in Table 4

Table 4 Community Taboos

| Taboos | N | Percentage |
|---|---|---|
| Sexual activity with pregnant spouses would cause harm to the unborn baby | 193 | 50.7% |
| Male partners become weak once they see their pregnant spouses naked | 73 | 19.2% |
| No known taboo in the community | 115 | 30.1% |

As presented on Table 4, majority of respondents 193(50.7%) reported sexual activity with their pregnant spouses would cause harm to the unborn baby, 73(19.2%) male partners become weak once they see their pregnant spouses naked and 115(30.1%) did not recognize the existence of any taboo in the community. One respondent reported that:

*"You stay for that long period waiting for your wife to deliver, this discourages men from being involved with most of her matters including the antenatal clinic."*

**Cultural Beliefs**

Results of the analysis of respondents' cultural beliefs in their community are presented in Table 5 According to these results majority 146(38.3%) of respondents reported that antenatal care is perceived as a woman's affair, 122(32%) reported male partners are ridiculed by the society while 113(29.7%) reported male partners feel embarrassed and ashamed.

**Table 5 Cultural Beliefs**

| Statements | N | Percentage |
|---|---|---|
| Antenatal care is believed as a woman's affair | 146 | 38.3% |
| Male partners are ridiculed by the society | 122 | 32% |
| Male partners feel embarrassed and ashamed | 113 | 29.7% |

In addition, one respondent reported that: *"The most frequently reported barrier for male involvement in antenatal care is the perception that antenatal care was a woman's activity, and it was thus shameful for a man to be found in such settings. This cultural barrier in itself without any other external influence demotivated us from attending antenatal care and getting involved in ANC*" (A Senior Manager, Kenya Government).

Another one reported that:

"***If I accompanied my wife to hospital every time she goes for her antenatal checkup, my friends would think I am a weakling. They would laugh at me because of cultural beliefs; most male partners do not like to accompany their wives to the antenatal clinics. Men who accompany their wives to***

***ANC are perceived to be weaklings by their peers"(A self-employed business man)***.

**Null Hypothesis**

There is no Relationship between Cultural Factors and Male Partner Involvement in ANC as contemplated in objective, the study hypothesized that cultural factors have no influence on male partner involvement in antenatal care in Kamenu Ward, Kiambu County. Pearson correlation (r) was used to examine the relationship between cultural factors and male partner involvement in ANC where determination coefficient (R2) was used to establish the percentage of the total variation that could be attributed to male partner involvement in ANC. First of all, all items of cultural factors were combined and averaged to form an index (cultural factors) before running the correlation analysis. Correlation coefficients, significance and determination coefficient (R2) results for hypothesis H02 are presented in Table 6.

**Table 6. Cultural Factors and Male Partner Involvement in ANC**

| Variables | cultural factors | male partner involvement |
|---|---|---|
| Cultural Factors | r | 1 | .331 |
| | P – value | .000 | |
| | N | 381 | 381 |

Male Partner Involvement

| | | | | |
|---|---|---|---|---|
| In ANC | r | .331** | 1 | |
| | p-value | .000 | N 381 | 381 |

Notes: Determination Coefficient (R2) = 0.109561 (about 10.96%). **Correlation is significant at the 0.05 level (2-tailed). Source

## IV. DISCUSSION

Correlation results on the relationship between cultural factors and male partner involvement in ANC revealed a weak significant positive relationship ($r = .331$, $p < 0.001$) Thus, it could be concluded that, cultural factors were a determinant of whether a male partner would get involved in his spouse ANC or not. The study identified male partners as decision makers 296(77.7%), family providers 293(76.9%) and head of the family 280(73.5%). The patriarchal role of these male partners was reflected in their identification of being in charge of household money and thus the decision maker of matters pertaining to antenatal care.

The fact that in most African cultures women are not allowed to lead, in this setting it is inconceivable for a woman to tell a man what to do, and worse still for him to assent to what she says. This norm is closely linked to other obstacles noted in the study findings, such as societal ridicule for men who accompanied their wives for ANC.

These results concur with studies in Nyanza County and Pacific that found out that male partners were the chief decision makers, head of the family and family providers thus are supposed to be busy working for the family (Kwambai, *et al*. 2013; Davis, *et al*, 2016).

## V. Conclusion

In conclusion, culture is a determinant of male partner involvement in ANC, the researcher recommends that County government through the community health strategy initiative and partnering with religious and the community leaders to avert the negative cultural influence through health education.

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