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Men Support for their Spouses in Accessing Safe Deliveries in Eastleigh North Division, Nairobi- Kenya: The Socio-Cultural Dilemma.

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Abstract: *Maternal health indicators in sub-saharan Africa are still low and in some cases, worrying. In most cultures, women's ability to seek health care is determined by the household head, usually the husband. However, due to the patriarchal nature of these societies, men always find themselves in a dilemma since they are not supposed to associate with women. The main objective of this cross sectional descriptive study involving 300 participants was to establish how socio- demographic factors influence how men support their spouses in accessing safe deliveries in Eastleigh North Division- Nairobi. The median age of the respondents was 33.0 while mean age of 36.0 years. Islam was the predominant religions at 73% and 53% were on polygamous relationships. 11% of the respondents had no any formal education at all. More than two third, i.e. 70% of the respondents confirmed that husband had the final say on wife health status. 64% and 82% indicated that their religious and cultural believe do not allow men into the labor ward respectively. Reason for not accompanying the wife to labor room were given as being turn away by health workers, religious beliefs and cultural taboos. There is a great need to involve religious and cultural leaders if meaningful involvement in of men in reproductive health issues was to be realized.*

Keywords: *Men support, Skilled Birth Attendant, Safe Delivery*

I. Introduction

In developed countries, unattended childbirth is one that takes place in a non-clinical setting, typically using natural childbirth methods, that takes place in a residence rather than in a hospital or a birth centre and usually attended by a midwife or lay attendant with experience in managing home births. Home births were the main method of delivery until the advent of modern medicine. Since the beginning of the 20th century, home birth rates have drastically fallen in most developed countries, generally to less than 1% of all births. Infant and maternal mortality rates have too dropped drastically over the same period [1].

Women with access to high quality medical care may choose a home birth because they prefer the intimacy of a home and family centered experience or desire to avoid a medically centered experience typical of a hospital. The births take place under the care of a professional. In developing countries, where women may not be able to afford medical care or it may not be accessible to them, a home birth may be the only option available and the woman may or may not be assisted by a professional attendant of any kind [2].

Studies have been conducted on the safety of home births for both the child and the mother as a standard practice, licensing requirements and the access to emergency hospital care differs between regions it can be difficult to compare studies across national borders. Medical studies in US found that perinatal mortality rates were triple that of hospital births. The study was done national wide on over 13 million births on a three-year span (2007-2010). It further reviewed that home births were roughly 10 times as likely to be a stillborn (14 times in first born babies) and almost four times as likely to have neonatal seizures or serious neurological dysfunction when compared to babies born in hospitals [2].

Throughout sub-Saharan Africa, home births are unattended and occur mainly due to multiple barriers to accessing proper healthcare. The area of pregnancy and childbirth in many African cultures is considered to be the responsibility of the woman. Therefore, it is rare to see men accompany women to antenatal care and be present for delivery [3]. Even in non-African settings, men negotiating a space for their involvement can be challenging.

Kenya has a maternal mortality ratio of 488 per 100,000 live births. Preventing maternal deaths depends significantly on the presence of a skilled birth attendant at delivery. Kenyan national statistics estimate that the proportion of births attended by a skilled health professional have remained below 50% for over a decade, currently at 44% [4] against the national target of 65%.

In Kenya, however, a clear association was demonstrated between male attendance to at least one antenatal care visit and delivery by a skilled birth attendant [5]. In addition, there have been multiple studies that explore the space for men in the area of antenatal care, delivery and the postpartum period [6], [7], [8].

Specifically, men can encourage their wives to attend and accompanying them to antenatal care, help prepare and save money for delivery, and arrange transportation to the birthing center, among other responsibilities [9].
According to a report [2], gender issues and in particular, the rights of women in Muslim culture continue to generate much media attention in the West. Muslim women are often portrayed as inferior beings, desperately in need of liberation from the Muslim patriarchal culture that prevents their progress. Segregation of the sexes, a practice encouraged by Islam, is often seen as proof of the suppression of Muslim women. This may greatly affect the decision making of the women towards uptake of safe delivery services. This is a reason to look deeper into men's involvement in the service provision.

Since the primary causes of maternal death are the result of the three delays; delay seeking care, delay reaching health care facilities and delay at an institution level in providing appropriate care, male support is always critical. Delays that occur can often be the result of women seeking support from the head of the household, often men. This is especially the case when the situation involves the need for funds. Involving men would allow them to support their partners to prepare for the delivery and seek out emergency care if necessary.

Studies have confirmed that socio-cultural factors have greater influence in male decision in utilization of skilled delivery and general involvement during pregnancy, a study in Uganda [10] indicated that men believed that issues related to pregnancy and childbirth were the domain of women. Involvement tended to be confined strictly to traditional gender roles, with men's main responsibility being provision of funds.

According to 1994 International Conference on Population and Development, plan of action, the global HIV/AIDS pandemic and high quality quantitative data on men from the Demographic and Health Surveys, there has been increased effort to include men in Family planning programs and there is no indication of the same in issues surrounding safe delivery. Women's ability to seek health care is determined by the household head, usually the husband. In spite of this, the extent of men's roles is not reflected in the amount of research carried out but social and cultural issues have always been implicated [11].

Eastleigh being largely a Muslim oriented region, the challenges to women in accessing medical care and in particular, safe and skilled birth attendant cannot be under estimated. A Muslim man is considered the head of the family, to many a man, however, this is a poisoned chalice because with leadership comes responsibility. Economic responsibility for maintaining the family falls squarely on the shoulders of the man irrespective of whether his wife is earning money. Unemployment, then, can greatly affect the integrity of the family, leaving the man in a role limbo. Psychological morbidity in such situations may be high, with ramifications for the family as a whole [12]. This study was therefore done find out how social and cultural issues affect men support for their spouses in accessing safe deliveries among women of reproductive age in Eastleigh north division, Nairobi County.

II. Materials And Methods

2.1 Study area

This study was conducted in Eastleigh North Division; Nairobi County with a population estimated to be 92,540 and has 54,482 households. The estimated number of women of reproductive age was 4,627 with an equal number of estimated deliveries and live births at the time of the study. Men aged 18-45years were 1383. The 2009 Kenya national census further showed 70% of the residents were Somali immigrants. The other community members are Ethiopians and others. The area is largely a community of Muslim believers with only an insignificant number being Christians who are operating businesses or are employed in the area.

2.2 Study design

The study employed analytical cross-sectional design and adopted both qualitative and quantitative data collection methods.

2.3 Study population

The study population comprised of all men 18 years and above in the study area.

2.3 Inclusion criteria

All married men aged 18 years and above in the study area, whose spouses had given birth within the last two (2) years and were willing to participate.

2.4 Sample size

The sample size determined by Fisher et al 1998 formula was 300 men.

2.5 Sampling procedures

Eastleigh North, the primary sampling unit, was purposively selected following a Sub County Health Management Team report of 2013that suggested that male partners act as obstacles when it comes to uptake of safe delivery services. The sampling units were randomly selected according to the population from which a house to house survey was adopted. The households were selected randomly.

2.6 Data collection method

The study used quantitative method to obtain data in-order to measure the different variables. This method was appropriate in this study as it is based on a larger sample sizes that are representative of the population.

Interviewer administered semi- structured questionnaire, were used to collect data and interviews were conducted by visiting households.

2.6 Pre-testing of data collection instruments

To establish reliability of the instrument, the questionnaire was pre-tested to a sample of 10-subjects in Kibra Laini Saba Location, a locality similar to the study area. This exercise was then concluded by rectifying spelling errors, ambiguous and culturally offensive terms.

2.7 Recruitment and training of enumerators

Community Health Extension Workers (CHEWs) were recruited as research assistants for this assignment and guides were drawn among the Community Health Workers (CHWs) from the community units within the study area. The researcher conducted a one day training to orientate the enumerators on data collection with emphasis on methods and techniques of asking questions so that they did not ask leading questions. Issues of confidentiality were highlighted and the data collection tools were tested and corrected a week prior to the actual data collection.

2.8 Data analysis

Descriptive statistics was analyzed and presented in tables, graphs and charts. Qualitative data was analyzed according to emerging themes. Frequency distribution tables was used to analyze the various variables while correlation and chi –square test were utilized to assess the relationships between selected variables. Regression analyses were also performed to show the strength of association between selected variable and men support for their spouses in accessing safe delivery services.

2.9 Ethical consideration

The research proposal was approved by the ethical research committee of Great Lakes University of Kisumu and authority to collect data was then sought from the relevant officers. Other major ethical issues which were adhered to during the process of study include: voluntary participation, informed consent, ensuring privacy and confidentiality of the respondents.

III. Results

3.1 Socio- demographic characteristics of the respondents

Table: Distribution of the respondents by their socio-demographic attributes

Age (Years)	Frequency n=300	Percentages
Age group of the respondents		
18-24	18	6%
25-29	30	10%
30-35	45	15%
35-40	153	51%
40-45	42	14%
Over 45 yrs	12	4%
Level of educational of the respondents		
None	33	11%
Primary	84	28%
Secondary	120	40%
College	36	12%
University	27	9%
Occupation of the respondents		
Business	165	55%
Employed	48	16%
Un employed	87	29%
Religious Affiliation of the respondents		
Catholic	27	9%
Protestant/other	48	16%
Muslim	219	73%
Hindu	6	2%
Marital status of the respondents		
Married	264	88%
divorced/separated	24	8%
Windowed	12	4%
Marital relationship of the respondents		
Monogamous Relationship	138	47%
Polygamous relationship	162	53%
Number of children respondents have		
Less than 3	66	22%
3 and above	234	78%

The socio-demographic characteristics of the study participants are summarized in Table 1 above. The respondents had a median (range) age of 33years and mean age of 36 years. A majority of the respondents 219(73%) were Muslims and 81(27%) of them were Christians consisting of 42(14%) protestants while 27(9%) were Catholics. Other religious affiliations reported were: 6(2%) Hindus.

As concerns marital status, majority of the respondents 264(88%) were married, 24(8%), separated/divorced and only 12(4%) were widowers. Of the married individual more than half 159(53%) of them were on polygamous relationship. The distribution of education levels showed that 120(40%) of the respondents had at least secondary levels of education, 84(28%) and 36(12%) had primary and college level of education respectively, 33(11%) had no education at all and only 27(9%) had at least university level.

When asked about their occupation, majority of the respondents 165(55%) reporting being businessmen; 87(29%) were unemployed and 46(16%) were on formal employment

3.2 Decision maker on woman's health in the family

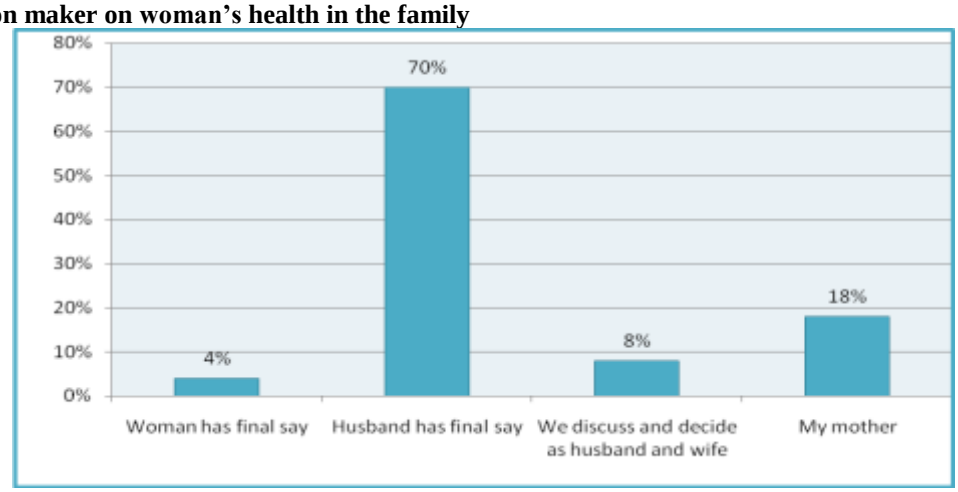

Figure 1: Distribution of the respondents by whom the decision maker on women's health is.

More than two thirds 110(70%) of the respondents confirmed that husband have final say on wife health status, while others, 54(18%) indicated their mother while only 12(8%) indicated they discuss with their wives and only 12(4%) indicated woman (wife) has final say.

3.3 Social Cultural Factors

Male religious affiliation had significant influence on male partner involvement (p=0.001). The men's cultural background also significantly influenced male partner involvement (P=0.001).

Table 2 Association between religion and male support for safe delivery

The dependent variable being Male involvement			Level of male involvement			Total	X^2	R	sig
			Low involvement	Moderate involvement	High involvement				
Religious barriers to entering labor ward	YES	n	0	36	72	108	1.24E2	-.909	0.001
		%	.0%	33.3%	66.7%	100.0%			
	NO	n	174	18	0	192			
		%	90.6%	9.4%	.0%	100.0%			
	Total	n	174	54	72	300			
		%	58.0%	18.0%	24.0%	100.0%			

Table 3 Association between culture and male support for safe delivery

The dependent variable being Male involvement			Low involvement	Moderate involvement	High involvement	Total	X^2	R	sig
Cultural barrier to entering labor ward	Yes	n	0	0	54	54	1.04E2	-.696	0.001
		%	.0%	.0%	100.0%	100.0%			
	No	n	174	54	18	246			
		%	70.7%	22.0%	7.3%	100.0%			
	Total	n	174	54	72	300			
		%	58.0%	18.0%	24.0%	100.0%			

Table 4 Reasons for not entering the labor wards when your wife goes to deliver

Reason for not entering labor ward		High involvement	X^2	R	sig
Male partner is head of household not for health facility	n	37	1.36E2	-.756	0.001
	%	12.3%			
Labor ward is only for women	n	194			
	%	64.7%			
To give health workers the ample to do their work	n	69			
	%	23.0%			
Total		300(100%)			

174(90.6%) and 54(82%) of the respondents cited their religion and culture respectively as the biggest obstacle to closely interacting with women. There were varied answers to the question of whether according to their cultural believe, a man is supposed to enter into the labor ward. Those who were against the idea cited reasons such as: 'delivery is not men's business, women can do it without men, my mother is enough, and other men do not enter it's against Islamic believe and that why should I and I have no idea what is done there'.

3.4 Reason for not accompanying the wife to labor room

Majority 68(39%) of the respondents who did not accompany their wives to labor ward reported that they were turned away by health workers, 48(27%) and 40(23%) cited religious beliefs and cultural taboos respectively. 10(5%) had no reason, and 6(4%) and 4(2%) cited social stigma and fear of the outcome of the baby and the mother respectively.

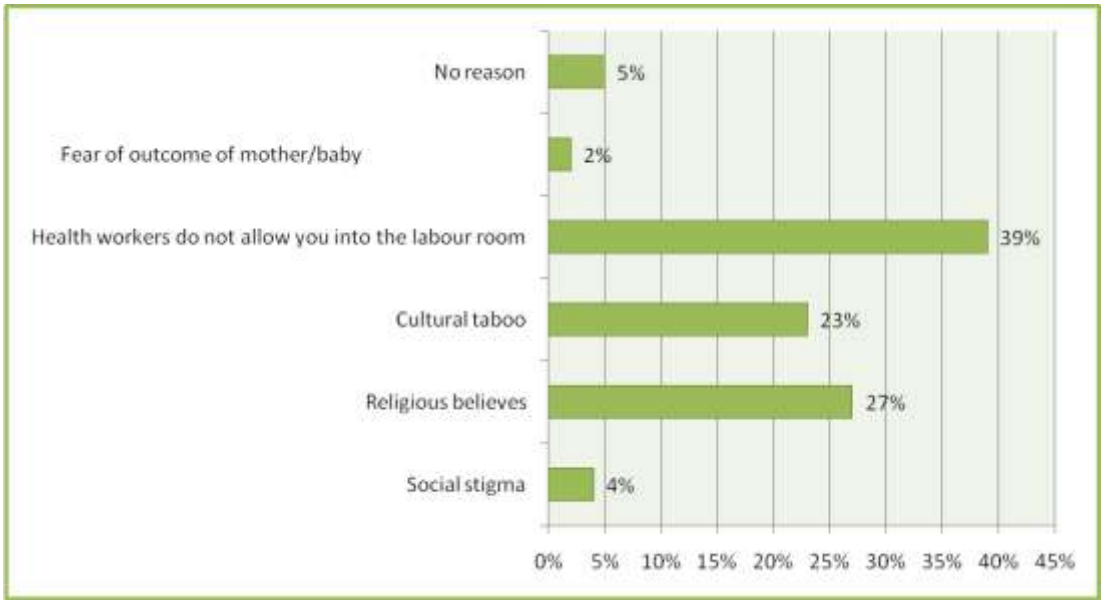

Figure 2: Reasons for not accompanying the wife to labor room

3.5 Association between socio-demographic factors and male support/involvement for safe delivery

In the bivariate analysis, as presented in Table 5 below, significant association was observed between the age, occupation, and educational status, health services affordability with male partner's involvement in accessing safe deliveries. Male partners' who were in the age group of less than 35 years were 3.96 times more likely to involved in support in accessing safe deliveries than those who were the age group of more than 35 years (95%CI=1.033, 15.188).

Male partners who were unemployed were 0.586 times less involved in support in accessing safe deliveries than those who were employed. Male partners who had no formal education and primary school were 0.937 times less involved in accessing safe deliveries when compared to Secondary school and above (95%CI=0.085, 0.0638).

Table 5: Association between Male support/Involvement and Socio-Demographic Characteristics

Characteristic		Low involvement		High/Moderate involvement		**OR**	**P-value**
		n=174	**%**	**n=126**	**%**		
Age (years)	<35	42	24.1	51	75.9	3.957	0.017
	≥35	132	75.9	75	24.1		
Marital Status	Unmarried	148	85.1	116	14.9	0.507	0.133
	Married	26	14.9	10	85.1		
Level of Education	Primary	74	42.5	43	34.1	0.937	0.046
	Post-primary	100	57.5	83	65.9		
Occupation	Unemployed	49	28.2	38	30.2	0.586	0.044
	Employed	125	71.8	88	69.8		
Religion	Christian	33	19.0	42	33.3	1.494	0.728
	Muslim/Hindus	141	81.0	84	66.7		
Marital Relationship	Monogamous	94	54.0	44	34.9	1.429	0.501
	Polygamous	80	46.0	82	65.1		

IV. Discussion

4.1 Socio-demographics

The results of this study revealed that majority of the respondents were middle aged individuals with those within age bracket of 35-40 years being the majority. In regard to religious affiliation, nearly three quarters, (73%), were Muslims, findings which link with the fact that majority of the residents in Eastleigh are from Somali origin and were of Islamic faith, (2009 Census). The study also, indicated that almost all of the respondents were married with more than half (53%) of them being on polygamous relationship. These findings therefore suggest that most men in the area may not be in a good position to provide maximum health related attention to each of their wives owing to their polygamous nature.

According to a study [13], multiple partner relationships was found to promotes different interests for the man and his partners and this hampered possibilities for transparent decision making on maternal health service issues. In addition to that, it was evident that almost all of the respondents had basic education, however significant minority 11% of them had no education at all, and findings which demonstrate that limited men's knowledge in maternal services may be relatively associated with inadequate knowledge. Study in Naigeria concluded that monogamous unions and increasing level of husbands' education were associated with spousal presence at delivery [14].

The study also revealed that more than half of the respondents were businessmen and others unemployed. According to another study [12], a Muslim man is considered the head of the family and has the sole responsibility for maintaining the family irrespective of whether his wife is earning money or not. Unemployment, then, can greatly affect the economic status of the family, leaving the man in a role question. In such state, priorities are focused towards providing food for the family and not health care, more so in issues that are assumed non illness like pregnancy and child bearing in general.

This study clearly demonstrated that husband have final say on wife health status that may suggest that wives have limited autonomy over their health and therefore rely on their husbands 'decision which may not attend to them satisfactorily, or even be reached timely. These findings relate well with Greene [15] study who found that in most cultures men have a big say on family decision making regarding maternal and reproductive health care and they often dominate in decision making in the society at large. Another study [16], also had similar findings where it was found that husband is often the primary decision maker and wife's economic dependence on her husband gives him greater influence on major household decisions.

4.2 Socio-cultural factors

Result of this study revealed that religious and cultural believes contribute significantly to limited involvement of men in maternal health services as nearly two third 64% and more than three quarters, 82% of the respondent confirmed that their religious and cultural believes discouraged men from entering the labor ward and almost all of them were contended with the same. It was difficult to untie cultural and religious believes because basically the culture of Somali community is deeply ingrained in the religious believes.

In this study male partners' who were in the age group of less than 35 years were 3.96 times more likely to involved in support in accessing safe deliveries than those who were the age group of more than 35 years (95%CI=1.033, 15.188).The more religious a man was, the more unlikely he was to be involved in the spouse's pregnancy and delivery activities. The results were similar for those that strongly believed in his cultural practices. These findings concur with those of another study in Uganda [10] who found that men believed that issues related to pregnancy and childbirth were the domain of women. Involvement tended to be confined strictly to traditional gender roles. A study in Gambia had similar findings which indicated that decision making power of men was grounded in religious obligations, cultural and traditional factors and the conventional view of husbands being providers and custodians of monies [2].

V. Conclusion

This therefore confirmed that majority of women in Eastleigh have very limited autonomy on their health. It was explicit that religious and cultural believes significantly contribute to limited involvement of men in maternal health services. Conclusively, men had limited involvement and support on spousal access to safe maternal healthcare and are predominantly hampered by religious and cultural taboos.

VI. Recommendations

Following the findings of this study, the researchers recommend that health intervention that seeks to encourage men to participate in spousal reproductive health be constituted. These would include community sensitization involving both religious and cultural leaders. This will greatly improve on spousal involvement and lead to increase in uptake of skilled delivery in the study area and can also be generalized to areas with similar settings and challenges on the uptake of the services.

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