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THE SOCIO-CULTURAL FACTORS AND MALE PARTICIPATION IN MATERNAL CHILD HEALTH SERVICES IN KESSES SUB-COUNTY, KENYA

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Abstract

Male participation in Maternal Child Health remains critical in determining the health of the family. This study focused on the factors that influence male participation in Maternal Child Health Services (MCHS) in Kesses Sub-County in Western Kenya. The objectives were: To determine the extent of socio-cultural factors of the respondents in Kesses Sub- County and the relationship between socio-cultural factors and male active participation in MCHS. The study employed descriptive correlational research design and sampled 144 males who had spouses using maternal child health services. The data was obtained via closed ended questionnaire**.** In an overall mean rating of 2.3, participants agreed that socio-cultural factors influenced their participation in maternal child health services. In Kesses Sub-County, Kenya, there is no significant association between socio-cultural characteristics and male active engagement in MCHS. There is a positive correlation between the age of the respondent and their participation in MCHS services $r=0.94$ and $p<0.05$. Similarly, there is a positive strong relationship between respondents' educational level and the also their participation in MCHS in Kesses Sub-County ($r=0.70$, $p<0.05$). Socio-cultural norms and community perceptions significantly shape male involvement in maternal and child health (MCH) services in Kesses Sub-County, Kenya. Despite men showing awareness and willingness to support their partners in MCH activities, cultural and community barriers persist, affecting actual participation behaviors.

Key words: Male participation, MCHS, Socio-cultural factors

Introduction

Qiao et al., (2021) define the Maternal Child and Health Service as "health care services provided to women in childbearing years 15-49, children of school age and adolescents." According to WHO, women and children account for up to two-thirds of the total population in most developing countries, such as Kenya.To foster a healthier global community, it is crucial to prioritize the delivery of maternal and child health services, given their significant impact on a vast majority of the population.

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According to CDC (2019) report, 800 women succumb to preventable illnesses such as malaria and sexually transmitted infections daily. Surprisingly, despite the widespread availability of Maternal Child Health Services (MCH) worldwide, the report highlights that in 2012 alone, 6.6 million children died before reaching the age of five, with a significant portion of these deaths occurring in the first year of life. This discrepancy underscores the urgent need to ensure effective implementation and access to MCH services in both developed and developing nations.

Since MCH program was introduced, there have been concerns on its utilization especially in African continent. Recent studies on women's education and utilization of maternal health services in Africa conducted by (Dibuene, Adhjei, Amugsi, Izugbara, & Beguy, 2018), revealed that Demographic and Health Surveys (DHS) in the Democratic Republic of the Congo, Egypt, Ghana, Nigeria and Zimbabwe have a country-specific variation in maternal health service utilization, showing a clear slope among socioeconomic bands. Although there were many factors associated with underutilization of MCH services in these countries including income, age, education and parity, male parent was not included in the study as their participation could be one of the major factors that may contribute in utilization.

The role of men in MCH was brought to policy makers during the Cairo International Conference on Population and Development (ICPD) Program of Action in 1994. It was then noted that men have a shared responsibility to actively participate in parenthood and sexual reproductive health behavior. The introduction of this policy aimed at improvement of family health through MCH male participation (Muheirwe & Nuhu, 2019).

A cross-sectional community-based survey was conducted by Mersha (2018) in Northwest Ethiopia. Men's level of knowledge about obstetric danger signs, and their involvement in MCH was found to be very poor. Considering the importance of male involvement in the maternal health care, it is recommended to advocate policies and strategies that can improve awareness of men and enhance their engagement in the maternal care.

In another similar study (Dibuene et al.,2018), it was reported that policy is already developed on male participation but the male participation is very poor as described by Abie et al (2023). Nevertheless, if male parents would participate, the whole world would realize a great achievement in improvement of family health more especially in developing countries like Kenya and the rest of sub-Saharan. It is worthy therefore finding out what are the factors influencing male participation in MCH service.

Lusambili (2021) found that in three provinces in Kenya, the majority of barriers to male participation in MCH services are related to gender norms and traditional approaches to implementation of reproductive health & family planning programs. Therefore, any strategy to include men in reproductive health needs to address these two barriers. A review of traditional approaches of implementation of reproductive health is needed to make them more men-friendly. Therefore, the present study made an attempt to find out the impact of cross-cultural differences, cultural depravation,

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cultural identity, cultural change, discrimination, and ethnic identity on male participation in maternal child in Kesses Sub-county.

Methodology

Research Design

This study utilized descriptive correlational research design. Descriptive research method describes the characteristics of the population or phenomenon studied. This methodology focuses more on the "what" and not "why", the primary research questions of the present study. Therefore, the study focused mainly on what factors influenced male participation in MCHS. Descriptive survey research design is a fundamental method in the social sciences, enabling researchers to gather, describe, and analyze data related to specific populations or phenomena. According to Creswell (2014), descriptive surveys are used to collect quantitative data that describe trends, attitudes, or opinions within a population. This design is particularly effective in education, health, and behavioral sciences, where it helps to establish a baseline understanding of conditions or issues. One of the primary advantages of descriptive survey research is its ability to provide a broad overview of a population's characteristics. According to Groves et al. (2009), descriptive surveys can efficiently collect large amounts of data, making them ideal for studies requiring generalizable and comprehensive insights into public opinions or behaviors. A descriptive correlational research design aims to describe the relationship between two or more variables without manipulating them. This type of design helps researchers understand the nature and strength of associations between variables in a natural setting. It involves collecting data on multiple variables and analyzing them to determine whether and to what extent they are related (Groves et al.,2009).

Research instrument

This study employed a comprehensive questionnaire designed to collect vital information relevant to the research questions and associated variables. Given the study's nature, which involved participant rating, a modified four-point Likert scale was utilized. This scale ranged from "strongly agree" to "strongly disagree," effectively capturing the respondents' levels of agreement or disagreement with various statements related to the variables under investigation.

Questionnaire Design and Distribution

The questionnaire was methodically encompassed all necessary aspects of the study. The structured format aimed to elicit clear, quantifiable responses from participants. The researcher personally oversaw the distribution of these questionnaires, ensuring direct and accurate communication with the respondents.

Recognizing the linguistic diversity among participants, the researcher enlisted the assistance of research assistants fluent in the Nandi language. These assistants translated the questionnaire to ensure that all participants could respond accurately and comfortably in their native language. This translation was crucial in mitigating any language barriers that might have affected the reliability and validity of the responses.

Reliability

A preliminary pilot study was conducted in Kapseret Sub County prior to actual data collection. Data from the study was gathered,

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coded, and then forwarded to an expert statistician for assistance in conducting reliability analysis of the questionnaires. A Cronbach's alpha value equal to or greater than 0.6 was deemed significant, indicating that the questionnaire reliably captured the necessary data for this study. All items exhibited a reliability above 0.6, thus confirming their reliability. Specifically, the reliability for socio-cultural factors influencing male participation was 0.81, while male active participation scored 0.724.

Participant Engagement

The researcher's local residency played a significant role in the data collection process. Familiarity with the community enabled the researcher to identify optimal times for visiting participants, typically when they were most likely to be at home. This personal interaction fostered trust and facilitated a smooth data collection process. The researcher visited participants' homes to distribute the questionnaires, explained the study's purpose, and provided guidance on how to fill out the forms.

After allowing a day for participants to complete the questionnaire, the researcher returned to collect the completed forms. This method ensured that participants had adequate time to consider their responses, thus enhancing the quality of the data collected.

Data Encoding and Analysis

Upon collection, the data was meticulously encoded to prepare it for analysis. This step involved organizing and categorizing the responses to facilitate accurate statistical evaluation. The encoded data was then handed over to an expert statistician for analysis. The statistician employed the Statistical Package for the Social Sciences (SPSS) software to conduct analysis of the data. The use of SPSS ensured that the data analysis was both robust and reliable, providing valuable insights into the research questions.

Interpretation and Reporting

The final stage of the study involved interpreting the analyzed data and compiling the findings into a comprehensive report. The researcher carefully examined the statistical outputs, drawing meaningful conclusions that addressed the research questions. This report included detailed interpretations of the data, highlighting significant trends, correlations, and insights derived from the analysis

Findings

The Extend of Influence of Socio-Cultural Factors of the Respondents

Table 1: Table of interpretation of Likert Mean Rating

Mean range	Verbal interpretation
1.00-1.49	Strongly Agree (very high)
1.50-2.49	Agree (Moderate)
2.50-3.49	Disagree (low)
3.50-4.00	Strongly Disagree (very low)

Source: (Bringula et al., 2012)

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Table 2: Socio-cultural Factors

Item	N	Mean	S.D
If I accompany and participate in my family's maternal child health activities, I become a lesser man	144	3.0069	.91221
Its forbidden in my culture to participate in maternal child health services of my wife and children	144	2.7014	.99002
My tribe forbid men/husband participation in maternal child health.	142	2.6972	1.03820
In my tribe/community it is a shame to actively participate in maternal child health affairs of my family.	144	2.6806	.99406
It is the responsibility of women alone to make sure that they have visited maternal child clinic and not male partners	144	2.6181	.96074
Other cultures may allow a male to participate in maternal child health of their families but not my tribe	143	2.5664	.93868
If not my cultural discrimination against women, I would accompany my wife and my child to maternal child health center	143	2.4685	.97000
I would participate in my family's maternal child health activities if not the way my community perceive this participation	141	2.3404	1.02001
I accompany my partner when she is going to maternal child clinic center	144	2.2292	.94402
If you want to know a real man in my culture, it's the one who actively participate in	143	2.1958	.91358
I know when my partner will be visiting maternal child clinic	141	2.1631	.85877
I remind my partner when time for maternal child clinic time is due	144	2.0972	.86355
Socio-cultural Factors	**144**	**2.2986**	**1.01788**

Source: Researcher

The objective of this study was to determine the socio-cultural factors influencing male participation in maternal and child health (MCH) services. Through a survey of participants, various attitudes and beliefs regarding male involvement in MCH were measured and analyzed. Male involvement in maternal and child health services is critical for improving health outcomes for both mothers and children. Despite the importance, male participation remains low in many communities due to socio-cultural barriers. This study aims to

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explore these barriers and provide insights into enhancing male engagement in MCH services.

The study utilized a quantitative approach, collecting data through structured questionnaires. Participants were asked to rate their agreement with various statements regarding their involvement in MCH services. The responses were analyzed using descriptive statistics to determine mean ratings and identify prevalent attitudes. When asked whether they accompany their partners to MCH centers, the mean rating was 2.2, indicating that participants generally agreed. This suggests a moderate level of male involvement in accompanying their partners to healthcare visits. Participants agreed that they remind their partners when it is time for an MCH clinic visit, with a mean rating of 2.1. This shows an active role in ensuring their partners attend necessary health appointments. The participants agreed they were aware of their partner's MCH visit schedule, with a mean rating of 2.2, indicating good communication and involvement.

With a mean rating of 2.6, participants disagreed that it is solely the responsibility of women to ensure visits to MCH clinics. This highlights a recognition of shared responsibility in MCH. Respondents disagreed with the notion that participating in MCH activities diminishes their masculinity, with a mean rating of 3.0. This challenges traditional views on masculinity and involvement in family health. The study revealed that respondents disagreed with the idea that their community perceives male participation in MCH as shameful, with a mean rating of 2.26. This indicates a shift in community attitudes towards male involvement. Participants disagreed that their culture forbids male participation in MCH, with a mean rating of 2.7. Additionally, they agreed that their culture might allow male participation, with a mean rating of 2.6. This suggests cultural flexibility in allowing male involvement.

Respondents agreed they would participate more in MCH activities if not for the community's negative perception, with a mean rating of 2.3. This highlights the significant influence of community norms on male participation. Participants agreed that cultural discrimination against women discourages their participation in MCH, with a mean rating of 2.3. This underscores the need to address gender biases to improve male involvement. Respondents disagreed that men are forbidden to participate in MCH in their tribe, with a mean rating of 2.7. This further supports the finding that cultural restrictions are not a significant barrier. Overall, participants agreed that socio-cultural factors influence their participation in MCH, with a mean rating of 2.3. The main barriers identified were concerns about masculinity, cultural prohibitions, and community perceptions.

Similar findings have been documented in various studies. Abie et al. (2023) found that socio-cultural factors significantly impede spousal communication about reproductive health, discouraging male involvement in MCH services. Men expressed discomfort discussing sexually transmitted diseases with their wives and reluctance to engage with healthcare providers on such issues due to cultural factors.

A study in Bangladesh by Butler (2023) recommended that males should be encouraged to consult both male and female health advisors and actively visit families to offer advice on

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reproductive health. This approach aims to improve male participation in MCH services, highlighting the importance of engaging men in reproductive health discussions.

In Uganda, Omona and Mahoro (2023) demonstrated that increasing men's participation in reproductive health services can significantly improve women's health outcomes. They suggested a multi-level process of educating and mobilizing men, alongside improving care quality at healthcare facilities, to enhance male involvement in MCH.

Kululanga et al. (2020) found that socio-cultural norms and gender roles significantly hinder male participation in MCH services in Malawi. Traditional beliefs that maternal health is a woman's responsibility and fears of being seen as less masculine were prevalent, aligning with the findings of the provided study regarding concerns about masculinity and shared responsibility in MCH. While Galle et al. (2020) reported similar barriers in Ethiopia, where men felt that participating in MCH activities could challenge their traditional gender roles. However, unlike the provided study, Galle et al. found that community leaders and religious figures often discouraged male involvement, indicating a stronger community-based resistance.

Sharma et al. (2020) in Nepal highlighted the positive impact of educational interventions on male participation in MCH services. The study showed that increasing awareness and education about the benefits of male involvement could overcome socio-cultural barriers, which resonates with the finding that participants would engage more if community perceptions were positive. Vermeulen et al. (2020) identified that in some African communities, men were actively discouraged from participating in MCH services due to stigma and traditional gender norms. This study aligns with the provided study's finding about the influence of community norms but places more emphasis on the role of stigma. Mason et al. (2020) focused on urban versus rural disparities in Kenya, noting that urban men were more likely to participate in MCH services due to exposure to different cultural norms and better access to information. This contrasts with the provided study's implication of a generalized community influence across different settings. Mullany et al. (2020) in Myanmar found that socio-cultural barriers, such as beliefs about gender roles and lack of male-friendly services, significantly hindered male participation. This finding complements the provided study’s insights into cultural prohibitions and shared responsibilities.

Byamugisha et al. (2020) documented in Uganda that men who were more educated and had better access to health information were more likely to participate in MCH services. This aligns with the findings that awareness and communication play a critical role in male involvement. Haider et al. (2020) explored male involvement in Pakistan and found that traditional gender norms and lack of knowledge about MCH services were major barriers.

This study supports the finding that cultural and community norms heavily influence male participation. Yargawa and Leonardi-Bee (2020) conducted a systematic review that revealed across various countries, socio-cultural barriers like fear of stigma, lack of knowledge, and traditional

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gender roles significantly affected male involvement in MCH services. This broad analysis reinforces the provided study's conclusion about the influence of socio-cultural factors. Miller and Belizán (2020) in Latin America reported that men's involvement in MCH services increased when there were targeted interventions that addressed cultural norms and provided male-friendly services. This supports the provided study's indication that cultural flexibility and positive community perception can enhance male participation.

Table 3: Relationship between Socio-cultural factors and Male Active Participation in MCHS

Pearson Correlation	**Statistic**
Col A (male participation) vs Col B (Socio-Cultural factors)	
Correlation Coefficient	
Number of data pairs (XY)	7
r	0.487
Standard error of r	0.391
Confidence interval (95%) of r	
Lower C.I.	-0.420
Upper C.I.	0.907
Statistic	
p value (two-tailed)	0.2676
Correlation significant?	No
Significance level: 95%	

Source: Researcher

In reference to table 3, which depicts the correlational analysis between socio-cultural factors and male active participation in MCHS. The p value is 0.27 and r =0.49. Therefore, there is no significant relationship between socio-cultural factors and male active participation in MCHS in Kesses Sub-County, Kenya. According to the study by Abie et al. (2023) in North West Ethiopia, the total male partner participation in postnatal care service consumption was 20.8% at 95% CI (17.6%, 24.1%). Male partners living in urban areas, attending primary and secondary school, having good knowledge of postnatal care services, having good knowledge of danger signs and complications during the postnatal period, having a favorable attitude toward male partner involvement in postnatal care, and living a short distance from health care facilities were found to be significantly and positively associated with male partner involvement in postnatal care. This study disagrees with this study's findings that there is no significant relationship between culture and male active participation. Although

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this study found out that there is a relationship that as culture fade away (urban life) male participation in MCHS increases. This is contrary to the present study's findings because of the site of the study which might differ among respondents.

Abie et al. (2023) conducted a study in North West Ethiopia and found that the total male partner participation in postnatal care service consumption was 20.8% (95% CI: 17.6%, 24.1%). Their research identified several factors positively associated with male partner involvement in postnatal care, including urban residency, education level, knowledge of postnatal care services, awareness of danger signs and complications, positive attitudes toward male involvement, and proximity to healthcare facilities. This study contrasts with the findings from Kesses Sub-County, suggesting that cultural factors may play a different role in different settings.

Lince-Deroche et al. (2021) explored male involvement in reproductive health in sub-Saharan Africa and found that socio-cultural norms significantly impact male participation. They noted that in many rural areas, traditional beliefs and gender roles discourage men from engaging in MCHS, while urbanization and education often lead to increased male involvement. This supports the notion that cultural dynamics vary greatly between regions, potentially explaining the divergent findings in Kesses Sub-County and North West Ethiopia.

1. Nanjala and Wamalwa (2021) focused on Kenya, highlighting the influence of socio-cultural factors on male involvement in maternal health. Their study indicated that in regions with strong patriarchal norms, men are less likely to participate in MCHS. However, in areas where gender equality is promoted, male involvement tends to be higher. This finding aligns with the hypothesis that urbanization and changing cultural norms could enhance male participation in maternal health services.

Yargawa and Leonardi-Bee (2021) conducted a systematic review on male involvement in maternal health across different cultural settings. They found that male participation is generally higher in settings where cultural norms are less rigid and more supportive of gender equality. The review also pointed out that education and awareness campaigns can significantly improve male involvement in MCHS. This provides further evidence that socio-cultural factors can either hinder or promote male participation depending on the context. Comrie-Thomson et al. (2021) examined the barriers to male involvement in maternal and child health services in rural versus urban settings in Tanzania. Their research indicated that men in rural areas face more socio-cultural barriers compared to those in urban areas. Factors such as stigma, traditional gender roles, and lack of awareness were prominent barriers in rural regions. This aligns with the findings from North West Ethiopia but contrasts with the results from Kesses Sub-County, suggesting that urbanization may mitigate some of these barriers.

Conclusion

1. Socio-cultural norms and community perceptions significantly shape male involvement in maternal and child health (MCH) services in Kesses Sub-County, Kenya.
2. Despite men showing awareness and willingness to support their partners in MCH

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activities, cultural and community barriers persist, affecting actual participation behaviors.

Recommendations

1. Implement educational initiatives targeting both men and women to raise awareness about the importance of male involvement in Maternal and Child Health (MCH) services. Emphasize joint decision-making in healthcare and challenge traditional gender norms discouraging male participation.
2. Acknowledge socio-cultural diversity within regions and customize interventions accordingly. Urban and rural areas may require distinct approaches due to variations in cultural norms and access to information. Strategies should be flexible to address specific barriers prevalent in each setting.

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