The influence of gender-stereotypic cultural norms and a maternalistic social structure on sexual and reproductive health outcomes among the Digo community of Kwale, Kenya

Vernon Mochache
International Centre for Reproductive Health, Kenya

Share-Net 5th Annual Meeting: Linking Research, Policy and Practice
De Balie, Amsterdam
28th September 2016

Presentation outline

- Background
- Research question
- Objectives
- Methodology
- Findings
- Discussion
- Conclusion

Background

- SRH outcomes (including MNCH/FP) influenced predominantly by 'supply-side' factors
  - Health system factors
    - Adequate # and training of different health cadres
    - Availability and functionality of supplies and equipment
    - Adequate financing

- Extending coverage of interventions that only target these factors may not necessarily result in improved health outcomes
  - Within complex socio-cultural contexts

Background

- ‘Demand-side’ factors:
  - Social structure (kinship networks, social institutions, social stratification)
  - Religious and cultural norms (symbols, practices, cultural evolution)

- Supply-side factors affect availability of health services while those on demand-side affect utilization of these services

Background

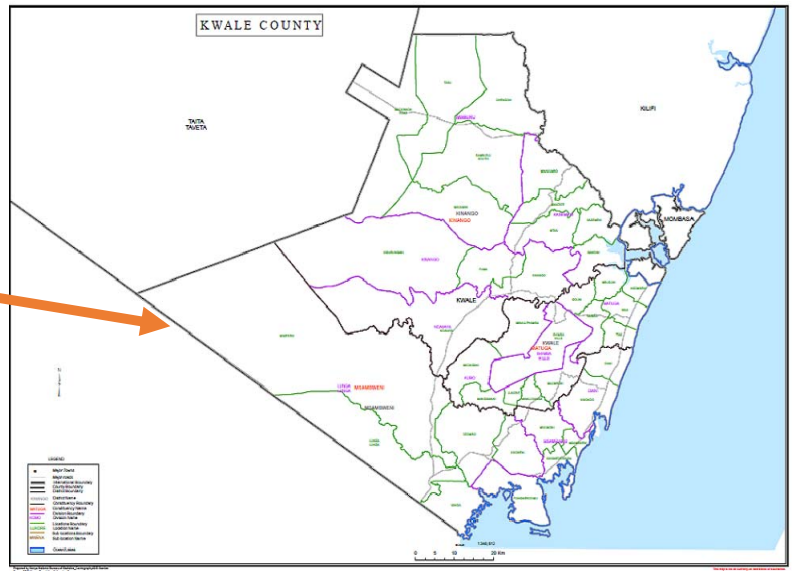
- Digo community:
  - 1/9 sub-tribes of the Mijikenda ethnic group in coastal Kenya (and northern Tanzania)
  - Bantu in origin
    - Similar linguistic origins but culturally diverse
  - Bantus languages descend from a common Proto-Bantu language
    - Spoken in what is now Cameroon in West Africa
    - Migrated eastwards and southwards about 2500-300 years ago
    - Dominate east and southern Sub-Saharan Africa east of Cameroon - constitute nearly the entire population


Berber
Arabic
Songhay
Hausa
Fulani
Yoruba
Igbo
Amharic
Oromo
Lingala
Kongo
Swahili
Chewa
Xhosa
Sotho
Afrikaans
Malagasy
Afro-Asiatic
Nilo-Saharan
Niger-Congo A
Niger-Congo B (Bantu)
Khoi-San
Austronesian

Background

- Digo community:
  - Population = 313,000 (2009 Kenya National Census)
  - Lexical similarity with other Mijikenda sub-tribes but most remote of the others
  - Strong Islamic influence (79.9%)
  - Predominant community in Kwale county


35°
40°
5°
0
150
300 mi
0
200
400 km
ETHIOPIA
SOUTH SUDAN
Mandera
Lodwar
SOMALIA
Marsabit
UGANDA
Wajir
Maralal
KENYA
Bungoma
Kitale
Busia
Eldoret
Isiolo
Nyahururu Falls
Nanyuki
Meru
Equator
0°
Kisumu
Nakuru
Nyeri
Embu
Garissa
Kericho
Murang'a
Kisii
Thika
Nairobi
Machakos
Lamu
INDIAN OCEAN
Voi
Malindi
TANZANIA
Mombasa
Tanga
5°
© 2011 Encyclopædia Britannica, Inc.


KWALE COUNTY

Background

- Kwale County:
  - Population = 649, 931 (2009 Kenya National Census)
  - Predominant Digo community (followed by Duruma)
  - 4 sub-counties:
    - Matuga
    - Msambweni
    - Lungalunga
    - Kinango

Background

- Kwale County:
  - Predominantly female population (51%)
  - Rural-based community (20% urbanization rate)
  - Sources of livelihood:
    - Fishing
    - Farming
    - Trading
    - Tourism

Background

- Kwale County:
  - Poverty level high = 74.9%
  - Life expectancy at birth = 53 years
  - TFR = 5.7 live births per woman
  - CBR = 48 per 1000 births
  - CDR = 14 per 1000 births
  - U5MR = 1118 deaths per 1000 births
  - MMR = 650 deaths per 100, 000 births

Background

- Previous study in Kwale showed 80% women had accessed ANC services but nearly half (46%) gave birth at home
- Also, knowledge and uptake of family planning (FP) was generally low with 61% of mothers not using any method
- Of those who did not utilize FP services, only 2% gave health system barriers as the main reason for non-use
  - Other reasons cited included:
    - Experience and fear of side effects
    - Socio-cultural factors including those related to spousal or in-law objection
    - Religious prohibition

Research Question

HOW and to WHAT EXTENT do ‘demand-side’ factors influence sexual and reproductive health (SRH)-related attitudes and behaviors among the Digo and what is the effect of this influence on health outcomes?

Overall Objective

- To develop a better understanding of socio-cultural context in this community so as to complement pre-existing intervention strategies and provide an efficient framework for developing sustainable interventions
  - That are effective but also readily acceptable given their responsiveness to local cultural context

Specific Objectives

1. To explore and determine the social structure of the Digo community with particular emphasis on social networks (kinship), social institutions (religious, political and economic), social stratification as well as the dynamics of social vulnerability

Specific Objectives

2. To explore and determine the cultural norms of the Digo community with particular emphasis on cultural symbols (myths, traditions/rituals and beliefs), cultural practices as well as their cultural history and its evolution

Specific Objectives

3. To determine how the social structure and cultural norms of the Digo community influence SRH-related attitudes and behaviors and how this influence affects health outcomes
   - To determine the community perceptions on health service delivery including challenges and barriers to accessing SRH services
   - To determine community perceptions on family planning services including factors that influence uptake and utilization of these services
   - To determine community perceptions that influence choice of place of delivery including a description of the decision-making pathways

Methodology

- Overarching ethnographic approach adapting a social-analytic conceptual framework (Price & Hawkin's)
  - Social analysis of the dynamics of social vulnerability, social capital and gender-stereotypic attitudes and roles
  - Grounded on Clifford’s Geertz interpretive approach which seeks to interpret the meaning of cultural practices and symbols (as opposed to positivist approach)

Methodology

- Complemented by a series of mixed-methodology sub-studies (both EU-funded):
  - Missed Opportunities in Maternal and Infant health (MOMI) project
  - Mama Na Mtoto (MNM) II project
    - Collaboration with Aga Khan University, Department of Community Health

Methodology

- Secondary review of information from primary and secondary sources
  - Literature review
  - Review of historical documentation and official records
- Quantitative data collection
  - Female household survey (15-45 years)

Methodology

- Qualitative data collection methods
  - Compilation of field-notes
  - Semi-structured key-informant interviews (KIIs)
  - Focus group discussions (FGDs)
    - local administrators, religious leaders, healthcare workers, village elders as well as both male and female community members

Findings

- Migration to eastern coast of Kenya & Tanzania
  - Interaction with Muslim Arabs and Persian traders – mixed bantu community
  - Strong Arab and Islamic influences
    - Not typical of other bantu groupings

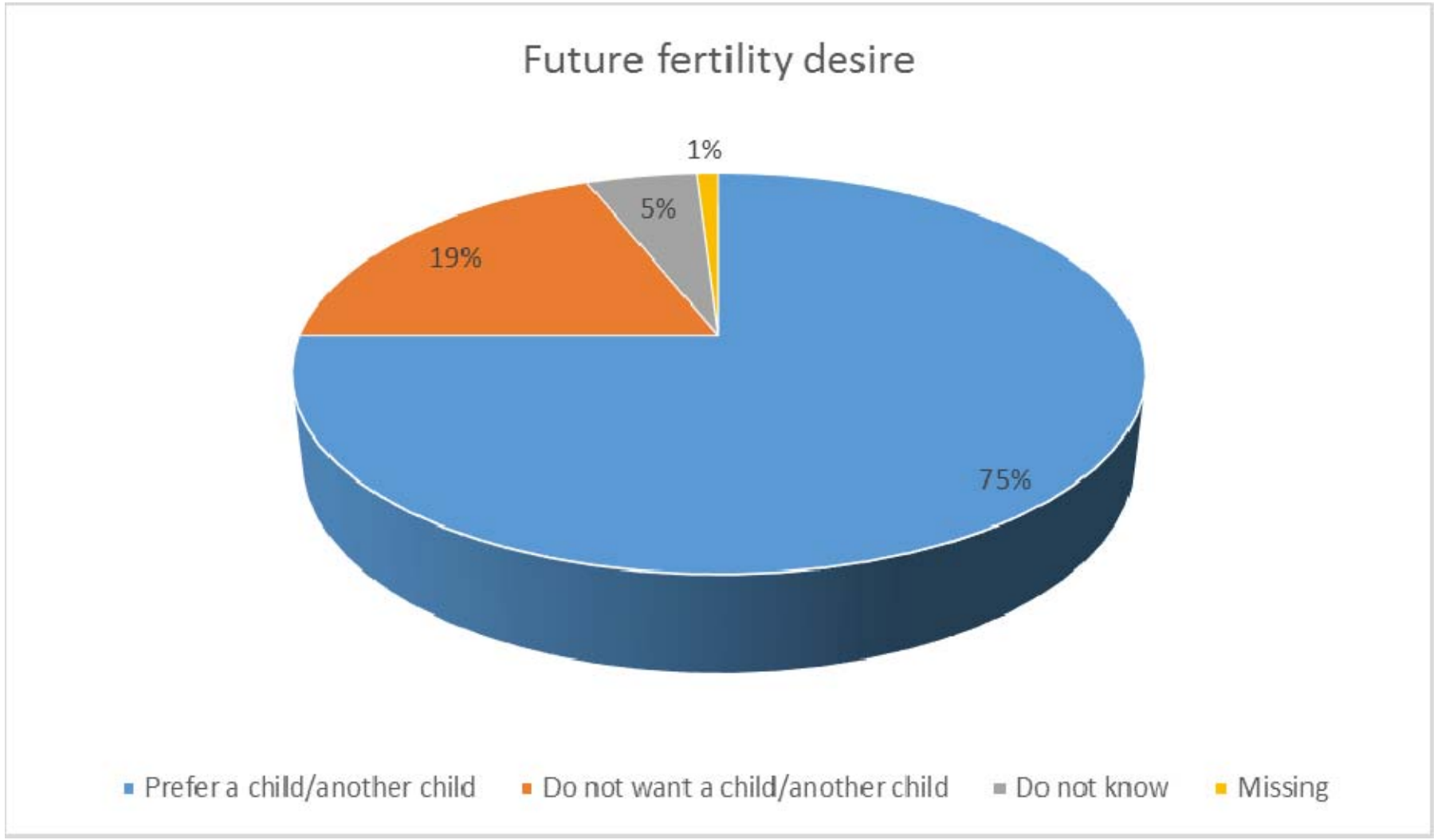
Findings

- Traditionally adopted a maternalistic social structure – deference to the 'wisdom' of an older maternal figure (grandmother, mother, mother-in-law, aunty)
- Played prominent role in the decision-making pathway regarding place of delivery
    - **Interviewer**: Tell me how it used to happen…..
    - **Respondent 1**: Our grandmothers, even our mothers, if a woman was in labor, the father would say we should wait first and the mothers would take charge…(*46 year old, 7 children, 5 currently alive*)
    - **Respondent 2:** I do that work. I have assisted all my children to deliver. But one thing upset me**.** I was asked to take a lady to hospital to deliver. When I reached there the doctor asked me why I did not take her to xxxx, and I told him there was no medicine there. He told me even at that hospital there was no medicine, he told me medicines are over……(*60 year old, 10 children*)

Findings

- Household survey:
  - Data collection between March and December 2015
  - SRH questionnaire to 745 female respondents (18-45 years old) from 15 villages

Characteristic	N(%)/Median (IQR)
Estimated age	29 (22-37)
Calculated age	29 (23-37)
Ever attended school	646 (87%)
Years of education	8 (7-11)
Ever given birth	632 (85%)
Total # of births	4 (2-5)
# children living together	3 (2-4)
# children not living together	2 (1-3)
# children currently alive	3 (2-5)
# children born alive then died	1 (1-2)
Currently pregnant	75 (10%)
Duration of current pregnancy	6 (4-7)
Previous pregnancy loss	158 (21%)
Years since last pregnancy loss	5 (2-11)
Pregnancy duration at loss	3 (3-4)
Marital status	
Currently married	426 (57%)
Currently living as if married	142 (19%)
Currently not in a union	177 (24%)


Future fertility desire
1%
5%
19%
75%
Prefer a child/another child
Do not want a child/another child
Do not know
Missing

Findings

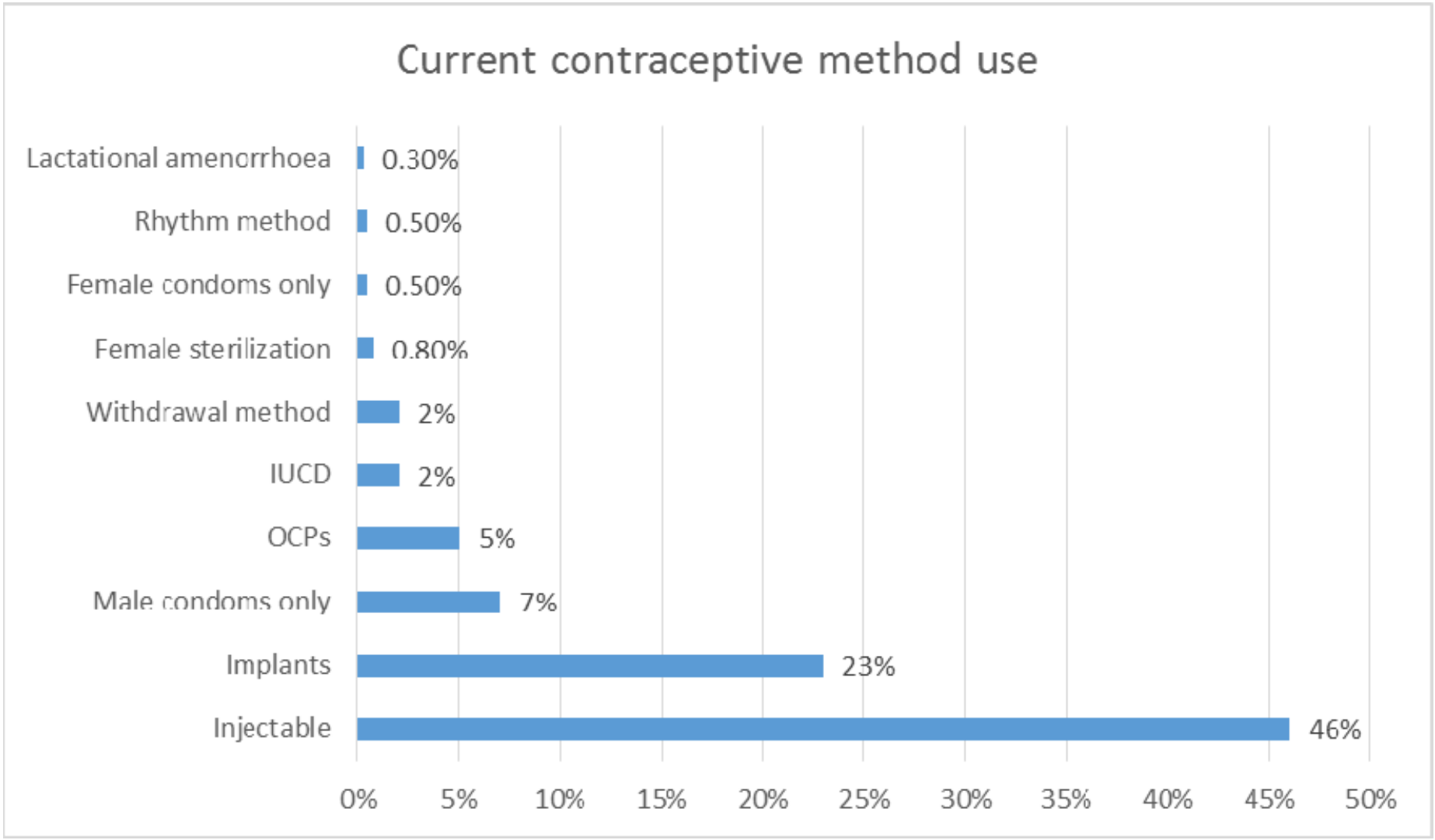
- Among respondents who reported:
  - Not wanting any more children, not knowing whether they wanted any more children, wanting another child but preferring to wait for some years or not knowing how long they wanted to wait before getting another child
    - 290 (44%) were not currently using FP (total unmet need)

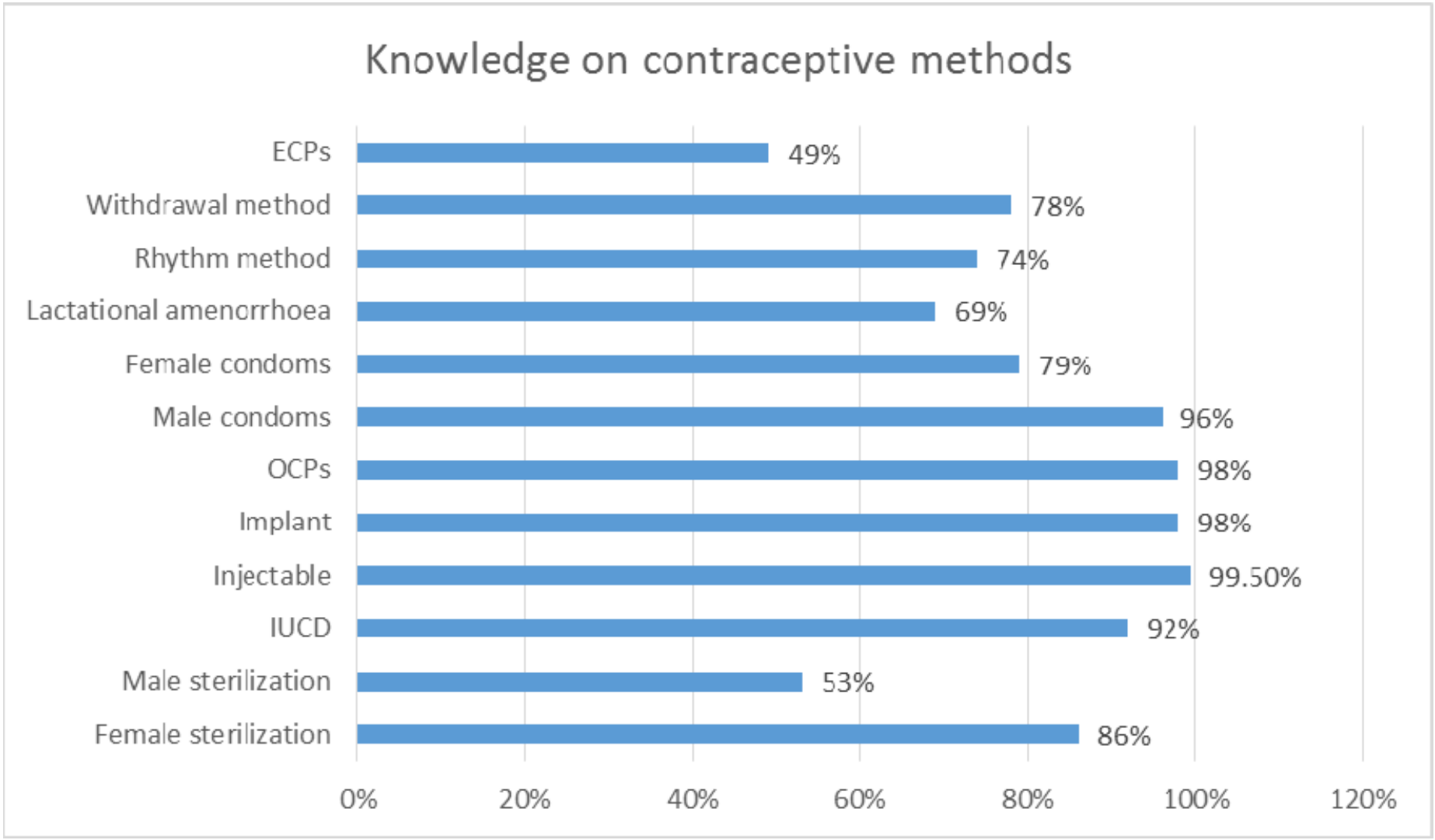
Findings

- Among respondents who reported:
  - Not wanting any more children or not knowing if they wanted any more children
    - 93 (52%) were not currently using FP method (unmet need for limiting)

Findings

- Among respondents who reported:
  - Wanting another child but after several years or did not know how long they wanted to wait before getting a child/another child
    - 199 (41%) of these were currently not using an FP method (unmet need for spacing)


Current contraceptive method use
Lactational amenorrhoea
0.30%
Rhythm method
0.50%
Female condoms only
0.50%
Female sterilization
0.80%
Withdrawal method
2%
IUCD
2%
OCPs
5%
Male condoms only
7%
Implants
23%
Injectable
46%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%
50%


Knowledge on contraceptive methods
ECPs
Withdrawal method
Rhythm method
Lactational amenorrhoea
Female condoms
Male condoms
OCPs
Implant
Injectable
IUCD
Male sterilization
Female sterilization
49%
78%
74%
69%
79%
96%
98%
98%
99.50%
92%
53%
86%
0%
20%
40%
60%
80%
100%
120%

Findings

- Decision to use FP method:
  - 222 (74%) respondents said it was a joint decision
  - 58 (19%) respondents said it was their own decision
  - 20 (7%) respondents said it was their husband/partner's decision

Findings

- Fertility-related reasons for non-use
  - I am not married/in a sexual union = 55 (19%)
  - I am not currently having sex = 48 (17%)
  - I am not having sex frequently = 6 (2%)
  - I am menopausal/had a hysterectomy = 4 (1%)
  - I cannot get pregnant = 11 (4%)
  - I am currently pregnant or breastfeeding = 116 (40%)
  - I have not seen my period since last delivery = 23 (8%)
  - I believe getting a child (or not) is up to God = 28 (10%)

Findings

- Opposition to use
  - I am personally opposed to FP use = 9 (3%)
  - My husband is opposed to FP use = 16 (6%)
  - My religion prohibits FP use = 13 (4%)

Findings

- Method-related reasons for non-use
  - Side effects/health-related concerns = 41 (14%)
  - FP use inconvenient = 8 (3%)
  - Other method-related reasons = (4%)

Findings

- **Interviewer**: For those who don't use, why don't they use these methods, what reasons do they give
- **Respondent 1**: My daughter used a family planning method one time, but later I heard her complain that if she used them they brought her a lot of pain……
- **Respondent 2**: My children don't use family planning….**Interviewer**: They don't use? **Respondent 2**: No they don't……Normally they don't give birth to another child until the other is 5 years old and going to school……**Interviewer:** And how do they manage to stay that long without getting a pregnant if not using family planning?
- **Respondent 2**: It depends, during my time, I have been spacing my child birth to 5 years….**Interviewer**: What did you do to achieve that spacing because others give birth after every 2 years, so what did you do? **Interviewer**: I did not use any thing and I gave birth after every 5 years…..(*50 year old, 5 children)*

Discussion

- SRH outcomes in a rural, developing world setting cannot be fully explained using an individualistic framework
  - Entrenched within complex socio-cultural contexts
- Better understanding of context = more efficient framework for developing sustainable interventions that are culturally-acceptable and locally-responsive

Conclusion

- SRH interventions among the Digo community should focus on engaging dominant maternal figures (implication for policy and practice)
  - Gender mainstreaming
  - Female empowerment