

Original Research Article

Determinants of male involvement in partner's cervical cancer screening in Makueni County, Kenya

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ABSTRACT

Background: Cervical cancer is the fourth cause of cancer deaths globally and is ranked in Kenya as the second cause of cancer-related deaths among females. Men are crucial in minimizing cervical cancer burden. This study sought to establish the socio-cultural and economic factors determining male involvement in their partner's cervical cancer screening in Makueni County, Kenya.

Methods: A mixed-method cross-sectional study was used to obtain quantitative and qualitative data from men using questionnaires. Participants were married men aged 18-64 who sought services at three mid-level rural hospitals in Makueni County. Three key Informant face-to-face interviews were conducted. Quantitative data were analyzed using descriptive statistics and inferences. Qualitative data was analyzed through codes and themes.

Results: The study included 291 men. Men's involvement in their partner's cervical cancer screening was low. Only 18% of the participants showed high involvement. The participants' mean age was 38.59 (SD±10.51). Younger men (median age=33 years) were significantly more involved than their older counterparts (median age=38 years) ($U=4363$, $p=0.020$). The level of male involvement was strongly linked to the rural area of residence ($p=0.001$) and the hospital where the respondents were interviewed ($p=0.012$). Other determining factors included employment status ($p=0.004$), educational level ($p=0.000$), and spousal screening history ($p=0.000$). The odds of male involvement were higher in men who understood their role in cervical cancer screening than those who did not (OR=4.550, 95% CI [1.307, 15.844], $p=0.017$).

Conclusions: Male involvement in their partner's cervical cancer screening remains significantly low, and demographics and sociocultural factors are key to these poor trends.

Keywords: Cervical cancer screening, Spouse, Sociocultural, Socioeconomic, Demographic, Factors

INTRODUCTION

In 2020, cervical cancer was the most diagnosed cancer and the fourth leading cause of cancer deaths among females globally, with 604,000 incidences and 342,000 fatalities reported.¹ Sub-Saharan Africa had the highest rate of cervical cancer cases and the lowest rate of screening. In Kenya, cervical cancer ranked as the second most significant cause of cancer-associated fatalities, with 12.4% (5,236) new cases and 11.9 (3,211) fatalities.²

Only 44% of women in low and middle-income countries had been screened for cervical cancer in 2020.¹

Globally, efforts are being made by each country, including Kenya, to achieve 70% cervical cancer screening coverage by 2030.³ However, data from 2018 and 2019 indicates that only 10.8% of eligible women in Kenya underwent screening for cervical cancer.⁴ Nurses play a key role in providing this service. To achieve this target, oncology nurses should understand social, cultural,

societal, and structural barriers to screening for cervical cancer. The research goal was to assist oncology nurses in identifying some of these barriers as reported by male respondents and address them to achieve the global cervical cancer screening target.

Obtaining male assistance through advocacy, education, and involvement in cervical carcinoma screening within socio-cultural norms would warrant men to make informed decisions relating to their spouse's cervical cancer screening. In Africa, men still act as superiors in the family.⁵ Several programs have measured men's involvement in various reproductive health (RH) contexts and found that male involvement has a positive impact on services such as FP, HIV prevention, antenatal care, and skilled birth attendance.⁶ A study done in Western Kenya on females' perspectives on male involvement in the human papilloma virus revealed that women had a perspective that men may have a crucial part in boosting HPV screening access.⁷ Low male involvement may result in fewer national screening.⁸

Men have a role in reducing cervical cancer burden by supporting their spouses financially, encouraging them to get screened, and provide emotional support.⁹ However, studies conducted in Swaziland, Ghana, and Kenya revealed that men had a limited understanding of cervical cancer and lacked awareness of risk factors, causes, signs, prevention, and treatment.⁹⁻¹¹ These studies focused on individual factors, neglecting sociocultural and economic aspects. Consequently, a knowledge gap exists regarding the local situation and determinants of male involvement in cervical cancer screening. Therefore, the current study aimed to establish the socio-economic and socio-cultural determinants of male involvement in their partners' cervical cancer screening.

METHODS

Study design and settings

Study employed mixed-method cross-sectional design, collecting quantitative and qualitative data to examine relationship between socio-cultural and economic factors and level of male involvement in cervical cancer screening. Study was carried out in Mbooni, Tawa, and Kisau mid-level rural hospitals, in Makueni County. Total of 291 respondents were sampled. The 3 mid-level rural hospitals were selected purposively, and respondents from each hospital recruited using simple random sampling. Study included men aged 18-64 years who were married and had female partners eligible for screening, residents of Mbooni Sub-County for at least year, able to speak English, Kiswahili/Kikamba, and have heard of cervical cancer. Men who physically/psychologically unstable, whose wives had undergone hysterectomy, were excluded from study. Key Informants were nurses in charge of mother and child health department where cervical cancer screening mostly takes place. Study's time frame was between August 2022 to August 2023.

Data collection

Data were collected using questionnaires. The researcher or the assistants assisted the clients who were illiterate in filling out the questionnaire. Those who were able to read and understand filled out the questionnaire by themselves. The questionnaire was both in English and the native Kikamba version. The questionnaires had open and closed-ended questions and were administered to 291 participants. The reliability of the instruments was measured through a test-retest approach whereby the researcher administered the same questionnaires to the same people on two occasions and then compared the responses. Content validity was used to measure the validity of instrument whereby questionnaires were checked to see whether it covers all aspects of concepts being measured. Face validity was verified by the supervisor first examining the questionnaires to determine whether the questions captured the targeted subjects. Additional information was obtained through key informant interviews which audio-taped and transcribed.

Analysis

The collected data was analyzed through descriptive statistics such as frequency tables, measures of central tendency, and measures of dispersion. Inferential statistics such as Chi-square, Fisher's exact, Likelihood ratio, and multivariate analysis using logistic regression were utilized to interpret the meaning of data and draw conclusions on the relationship between variables. Qualitative data obtained from open-ended questions and Key Informant face-to-face interviews were analyzed using codes and themes reported in narrative form. Statistical Package for Social Sciences version 25 aided in analyzing quantitative data.

Ethical considerations

Approval of the proposal was obtained from Kenyatta university graduate school while ethical approval was sought and obtained from Kenyatta university ethics review committee. NACOSTI and Makueni County Government gave the authorization to conduct the research. The information collected was kept confidential. The respondents gave informed consent. The researcher observed the privacy of the respondents, fair treatment of all respondents, and the principle of autonomy. The study observed the anonymity of the respondents by avoiding the collection of identifying information.

RESULTS

Socio-demographic factors

Men's involvement in their partner's cervical cancer screening was low, with only 18% (n=49) of the participants showing high involvement. The respondents had an average age of 38.59 years (SD=10.51). Among

the respondents, slightly above two-fifths (43%) were from Mbooni rural area with the rest coming from other rural areas. Regarding the hospital where the interviews took place, approximately two-fifths (41%) were conducted at Mbooni mid-level rural hospital with the rest conducted in Tawa and the Kisau mid-level hospitals (Table 1).

Table 1: Socio-demographic characteristics of respondents.

Characteristic	N	Percentage (%)
Rural area of residence (n=291)		
Mbooni	124	43
Kithungo/Kitundu	54	19
Tulimani	18	6
Kisau/ Kiteta	92	32
Others	3	1
Hospital (n=291)		
Mbooni mid-level	118	41
Tawa mid-level	91	31
Kisau mid-level	82	28

A cross-tabulation (Table 2) examined the relationship between male involvement and socio-demographic factors. The analysis revealed a strong association between male involvement and the rural area of residence ($p=0.001$), and the hospital where the respondents were

interviewed ($p=0.012$). The Mann-Whitney U test was utilized to assess the variation in ages based on the level of male involvement in their partner's cervical cancer screening. The results indicated that highly involved men (median age=33 years) were significantly younger than men with low involvement (median age=38 years), $U=4363$, $p=0.020$.

Sociocultural factors

Men were lowly involved in various social activities that support cervical cancer screening as shown in Table 3 below, with the majority (96%) saying they have never accompanied their spouses to the screening room. These findings concur with information from key informants (KI). The Key Informants rated men's involvement in cervical cancer screening as poor. For example, KI1 said, "It is very low". KI2 said, "The level is low". KI3 said "I would rate the involvement as minimal". They also said that they have never got any client accompanied by the spouse to cervical cancer screening. For example, KI2 said, "For the time I have worked here, No". KI3 said, "to be honest, I wouldn't say yes; I have never gotten a client with a spouse; it is usually the client who comes alone".

Regarding whether the spouse has ever been screened for cervical cancer, less than one-third (29%) of the respondents agreed that the spouse has ever been screened. The responses are shown in Table 4 below.

Table 2: Socio-demographic characteristics of respondents versus the level of male involvement.

Characteristic		The overall level of male involvement				Significant at p≤0.05
		Low		High		
		N	%	N	%	
Hospital	Mbooni mid-level	95	42	11	22.4	χ²=8.821 df=2 p=0.012*
	Tawa mid-level	66	29.2	24	49	
	Kisau mid-level	65	28.8	14	28.6	
	Total	226	100	49	100	
Rural area of residence	Mbooni	105	46.5	10	20.4	χ²=16.700 df=3 p=0.001*
	Kisau/kiteta	64	28.3	27	55.1	
	Kithungo/ Kitundu	43	19	7	14.3	
	Others	14	6.2	5	10.2	
	Total	226	100	49	100	

*. The Chi-square statistic is significant at the .05 level.

Table 3: Male's involvement in various activities to support cervical cancer screening.

Activity	Frequency	Percentage (%)
Offering financial support,**(n=281)		
Yes	50	18
No	231	82
Accompanying spouse to facility,*(n=276)		
Yes	35	13
No	241	87
Encouraging spouse to go for screening,****(n=286)		
Yes	96	34
No	190	66

Continued.

Activity	Frequency	Percentage (%)
Allowing spouse to go for screening, ***(n=282)		
Yes	92	33
No	190	67
Accompanying spouse to screening room, *(n=276)		
Yes	10	4
No	266	96

*(N=276), ***(N=282), *****(N=286)- due to incomplete filling of the questionnaire.

Table 4: Response of men to whether their spouse(s) are screened for cervical cancer.

Response	Frequency	Percentage (%)
Yes	84	29
No	115	40
I don't know	91	31
Total	289*	100

*(289)- due to incomplete filling of the questionnaire.

The majority of males (83%) thought that their spouses were not at risk for cervical cancer. Some of the reasons given by those who claimed that the spouse is not at risk for cervical cancer include the following: the wife does not drink alcohol; the spouse has already been screened and was found to be negative; cancer is not a common disease; cancer is for the rich; the family eats healthy foods; the couple is faithful to one another. One respondent said that because his wife is not overweight, she is not at risk. Those who believed their spouses were in danger of developing cervical cancer cited the arguments that "she is a woman and can get it, anyone can get it."

Half of men (50%) believed that they have a role in cervical cancer screening. All the Key Informants agreed that males have a role in cervical cancer screening. These comments illustrate this; KI3 stated, "*Men are involved in spreading HPV virus, I think they have a role in screening so that they know how it is spread and also be involved in protecting their partners*". KI2 said, "*They should support their women so that the women can agree to be done cervical cancer screening*". KI1 said, "*If men knew, they would help encourage their partners to come for screening and accompany them*".

Nearly two-thirds (65%) of the respondents believed that cervical cancer damages reproductive health organs. The majority (91%) believed that the topic of sexuality is too private and open discussion should not be allowed. Table 5 below shows men's beliefs about cervical cancer and its screening.

Some statements were posed to access myths and misconceptions about cervical cancer and its screening. Table 6 below shows the responses. Slightly above one-third (37%) falsely believed cervical cancer occurs in those who abort, 31% of the respondents falsely believed it occurs in those who use family planning and

approximately half of the respondents (51%) believed cervical cancer occurs in women with multiple partners.

Table 5: Men's beliefs regarding cervical cancer and its screening.

Variables	Yes, N (%)	No, N (%)
Spouse is at risk (291)	83 (30)	205 (70)
Men have a role in cervical cancer screening,* (n=290)	145(50)	145 (50)
Cervical cancer screening damages RH organs, (n=291)	103 (35)	188 (65)
Topic of sexuality is too private, and open discussion is not allowed,* (n=290)	27 (9)	263 (91)

*(290)-due to incompleteness of the questionnaire.

Table 6: Myths and misconceptions about cervical cancer.

Myths/ misconceptions and response	N	Percentage (%)
Cervical cancer occurs in those who abort, (n=291)		
True	108	37
False	183	63
Cervical cancer occurs in those who use FP,*(n=290)		
True	90	31
False	200	69
Cervical cancer occurs in women who have sex with several men,*(n=290)		
True	148	51
False	142	49

*(N=290)-due to incompleteness of the questionnaire.

Majority (73%) of the respondents said that the decision-making for a woman to seek health care services is jointly done. Figure 1 shows males' responses regarding the decision-maker for spouse (s) to seek health services.

The majority of respondents were Christians (97.3%), while the rest belonged to other religions. Almost all respondents (96.5%) reported that their religious beliefs supported cervical cancer screening.

Researchers conducted chi-square association test to examine sociocultural factors connected to male participation in cervical cancer screening. Table 7

findings reveal several significant associations with level of male involvement. Spousal screening history was associated with level of male involvement ($p=0.0$). Men with high level of involvement had larger percentage of spouses screened than men with low involvement. Perceived role of men in screening was significantly associated with male involvement ($p=0.000$). Men who believed they had a role in screening were more likely to have a high level of involvement.

Furthermore, male involvement was substantially related to assumption that spouse at risk of cervical cancer ($p=0.003$). Men who believed their wives were in danger were more likely to be active in screening. Men's beliefs about screening harm and privacy also influenced their involvement. Those who considered that screening harmless ($p=0.016$) and that sexuality talks should not be kept private ($p=0.033$) more likely to participate in cervical cancer screening. Additionally, men's involvement in health-related decisions significantly associated with their level of involvement ($p=0.001$). Men who believed that both spouses should be involved in health-related decision making had higher level of

involvement. Lastly, certain misconceptions about causes of cervical cancer significantly associated with low male involvement. Beliefs that cervical cancer occurs in women who use family planning ($p=0.029$), who have had abortions ($p=0.001$), have multiple sexual partners ($p=0.0$) linked to lower levels of male involvement.

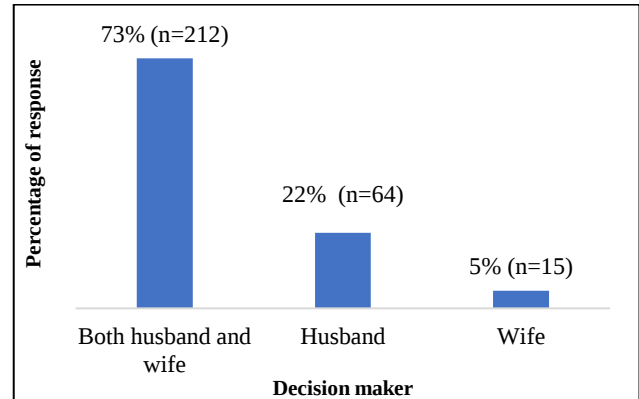


Figure 1: Men's belief on who makes decisions on health matters about women.

Table 7: Socio-cultural factors versus male involvement.

Sociocultural factors		Overall male involvement				Significant at p≤0.05
		Low		High		
		N	%	N	%	
Spouse has ever been screened	Yes	33	14.7	45	91.8	$\chi^2=117.762$, df=2, p=0.000*
	No	105	46.7	3	6.1	
	Don't know	87	38.7	1	2	
	Total	225	100	49	100	
Men have a role in cervical cancer screening	No	130	57.8	5	10.2	$\chi^2=36.435$, df=1, p=0.000*
	Yes	95	42.2	44	89.8	
	Total	225	100	49	100	
Believes partner at risk of cervical cancer	No	166	74.4	26	53.1	$\chi^2=8.843$, df=1, p=0.003*
	Yes	57	25.6	23	46.9	
	Total	223	100	49	100	
Decision maker for a woman seeking health services	Husband	60	26.5	3	6.1	L.R. p=0.001*
	Wife	14	6.2	1	2	
	Both	152	67.3	45	91.8	
	Total	226	100	49	100	
Cervical cancer screening damages reproductive organs	True	87	38.5	10	20.4	$\chi^2=5.770$, df=1, p=0.016*
	False	139	61.5	39	79.6	
	Total	226	100	49	100	
Cervical cancer occurs in those who abort	Yes	76	33.6	29	59.2	$\chi^2=11.142$, df=1, p=0.001*
	No	150	66.4	20	40.8	
	Total	226	100	49	100	
The topic of sexuality is too private and open discussion is not allowed	True	25	11.1	1	2	Fisher's exact p=0.033*
	False	200	88.9	48	98	
	Total	225	100	49	100	
Cervical cancer gets those who use family planning	Yes	65	28.9	22	44.9	$\chi^2=4.759$, df=1, p=0.029*
	No	160	71.1	27	55.1	
	Total	225	100	49	100	
Cervical cancer occurs in women with multiple sexual partners	No	105	46.7	38	77.6	$\chi^2=15.382$, df=1, p=0.000*
	Yes	120	53.3	11	22.4	
	Total	225	100	49	100	

*The Chi-square statistic is significant at the 0.05 level.

Socioeconomic factors

Majority of respondents (72%) had form of employment (40% self-employed, 32% employed). About 2/3rd 65%) had completed at least their secondary school. Nearly half (55%) of respondents reported having monthly income of less than Kshs 10,000. Socio-economic statuses of respondents are displayed in Table 8.

A Chi-square analysis established the relationship between socioeconomic characteristics and male involvement in a partner's cervical cancer screening (Table 9). Employment status ($p=0.004$) and educational level ($p=0.000$) were statistically significant.

From logistic regression (Table 10) the significant predictors of high men involvement were; an understanding that men have a role in cervical cancer screening ($OR=4.550$, 95% CI [1.307, 15.844], $p=0.017$), and the notion that cervical cancer does not occur in those who abort ($OR= 4.121$, 95% CI [1.015, 16.728], $p=0.048$). Men who believed they had a role in cervical cancer screening were 4.550 times more likely to be highly involved than those who did not believe they had a

role in screening their women. Similarly, those who did not believe cervical cancer occurs in those who abort were 4.121 times more likely to be involved in their spouse screening than those who did have such a belief.

Table 8: Socioeconomic characteristics of respondents.

Variables	Frequency	Percentage (%)
Employment status (n=291)		
Employed	94	32
Self-employed	116	40
Unemployed	81	28
Income, (shilling) (n=291)		
<10000	159	55
10,000-19,000	48	16
20,000-29,000	31	11
30,000-49,000	36	12
>50,000	17	6
Education, (n=291)		
Primary	72	25
Secondary	85	29
College	106	36%
None	28	10%

Table 9: Socioeconomic factors versus male involvement.

Characteristic		The overall level of male involvement				Significant at p≤0.05
		Low		High		
		N	%	N	%	
Income/month (shilling)	<10000	133	58.8	19	38.8	χ ² =6.599, df=3, p=0.086
	10000-19000	34	15	11	22.4	
	20000-29000	23	10.2	7	14.3	
	≥30000	36	15.9	12	24.5	
	Total	226	100	49	100	
Employment status	Salaried-employment	63	27.9	22	44.9	χ ² =10.962, df=2, p=0.004*
	self-employed	90	39.8	22	44.9	
	Unemployed	73	32.3	5	10.2	
	Total	226	100	49	100	
Education level	≤Primary	91	40.3	4	8.2	χ ² =24.341, df=2, p=0.000*
	Secondary	67	29.6	14	28.6	
	≥College	68	30.1	31	63.3	
	Total	226	100	49	100	

* The Chi-square statistic is significant at the 0.05 level.

Table 10: Logistic regression model showing the likelihood of a high level of male involvement in the partner's cervical cancer screening given the different independent variables.

Independent variables in the model	B	S.E.	Wald	Df	Sig.	OR	95% C.I. for OR	
							Lower	Upper
Hospital (Kisau3-Ref)			1.411	2	0.494			
Hospital (Mbooni-1)	0.669	0.707	0.894	1	0.345	1.952	0.488	7.810
Hospital (Tawa-2)	-0.213	0.691	0.095	1	0.758	0.808	0.208	3.133
Age (In years)	.038	0.027	1.975	1	0.160	1.038	0.985	1.095
Ref ward (Kisau/kiteta)			9.651	3	0.022			
Resident ward (Mbooni ward-1)	-1.269	0.668	3.608	1	0.057	0.281	0.076	1.041
Resident ward (Kithungo/Kitundu-2)	-.148	0.735	0.041	1	0.840	0.862	0.204	3.639
Other resident wards-3)	1.483	0.869	2.910	1	0.088	4.408	0.802	24.228
Men have a role in screening (Yes=1)	1.515	0.637	5.665	1	0.017	4.550	1.307	15.844

Continued.

Independent variables in the model	B	S.E.	Wald	Df	Sig.	OR	95% C.I. for OR	
							Lower	Upper
Ca. Cx damages RH organs (False=1)	0.673	0.524	1.649	1	0.199	1.960	0.702	5.474
Ca. Cx is caused by abortion (False=1)	1.416	0.715	3.925	1	0.048	4.121	1.015	16.728
FP causes Ca.Cx (False=1))	1.397	0.716	3.803	1	0.051	4.043	0.993	16.459
Multiple sexual partners, not a risk	-0.910	0.603	2.281	1	0.131	0.402	0.123	1.311
Unemployed-reference			1.686	2	0.430			
(Salaried-1)	0.918	0.724	1.608	1	0.205	2.505	0.606	10.355
(Self-employed-2)	0.774	0.690	1.257	1	0.262	2.168	0.560	8.390
Constant	8.295	2.092	15.721	1	0.000	0.000		

DISCUSSION

The study found that several socio-demographic factors were associated with men's involvement in their partner's cervical cancer screening. Age was a significant factor, with younger men showing higher involvement levels than older men, perhaps because younger men are likely to be more informed about emerging health challenges than older male participants. This finding aligns with a study done in Malawi which demonstrated that men under 45 were more likely to have a positive attitude towards gender equity in sexual matters and were more actively involved in their partner's screening.¹² The area of residence of the participants was also associated with male involvement in cervical cancer screening. The physical environment and the social determinants of health shape healthcare behaviors.¹³ In the context of this study, the level of male involvement may be influenced by the knowledge and perceptions of men residing in a specific area regarding cervical cancer screening. The hospital where the interviews took place was another factor associated with male involvement in their partner's cervical cancer screening. This association may be attributed to factors such as the accessibility and availability of screening services and the attitudes of healthcare staff. A study done in Kenya identified challenges to cervical cancer screening as poor availability of services, long travel distances to screening locations, extended waiting hours, and high screening costs.¹⁴ Similarly, a study done in Ghana found that negative attitudes among health workers could discourage clients from seeking screening.¹⁵

Half of the men in this study perceived their partners as not at risk for cervical cancer. This perception was linked to their low level of involvement in screening. Similar findings were reported by a study done in Sub-Saharan Africa which indicated that a belief that one is not at risk of the disease is a barrier to cervical cancer screening.¹⁶ The study also highlighted the knowledge gap among men regarding the dangers and the need for the prevention of cervical cancer. Misconceptions about risk factors, such as family planning and abortion, were identified. Multiple sexual partners were mentioned as increasing the risk and influencing male involvement in screening. These findings are supported by studies conducted in Ghana and in the USA which revealed that cervical cancer is gotten from promiscuous live.^{15,17} Men who had a favorable view that they had a role to play in

screening was more likely to be involved in cervical cancer screening. The findings could be linked to prevalent traditions and beliefs, as observed in a study done in Nigeria which found that males in some communities are expected to pay for their spouses' medical expenses regardless of their wives' work status.¹⁸ The perception that both partners should be involved in decision-making regarding healthcare differed from findings in Zambia and Nigeria, where men were seen as sole decision-makers.^{18,19} Lastly, beliefs that the topic of sexuality is too private and cervical cancer screening damages the reproductive system were linked to lower male involvement in cervical cancer screening. This concurs with a study done in Botswana which revealed that these two factors were barriers to cervical cancer screening.²⁰

Socioeconomic factors considered in this study include; income, occupation, and education.²¹ In the current study, many participants had completed their secondary education, which can contribute to high awareness of cervical cancer. Education level was associated with men's involvement in cervical cancer screening. This finding is consistent with a Swedish study which indicated, that women with low education levels were more likely to miss out on screening.²² This is also in concurrence with research done in Iran which demonstrated that poor reproductive health was less common among those with higher levels of education.²³ Poor education leads to inadequate knowledge, which could contribute to a low level of male involvement in their partner(s) cervical cancer screening. This study also reported that nearly half (55%, n=159) of respondents had a monthly income of less than Kenya shillings (KES) 10,000. The world bank defines a person as extremely poor when earning less than \$2.15 per day, currently equivalent to 307 KES per day and totaling approximately 9,500 KES per month. A person is said to be of lower middle income if earning less than \$3.65 (approximately KES 520) per day equivalent to approximately 16,000 KES.²⁴ This indicates that males in the study area cannot effectively support their partners on matters related to cervical cancer screening; hence financial factor continues to hinder the uptake of screening services. The analysis showed there was an association between monthly income and the level of male involvement in cervical cancer screening. These findings are in agreement with a study's report from Nepal and a study's report from South West Nigeria,

which concluded that lack of money is one of the obstacles to the screening of cervical cancer and that cervical cancer screening is influenced by economic/financial barriers.^{18,25} These barriers include financial constraints like the cost of travel to distant screening centers and screening services. They could have influenced men's participation level in cervical cancer screening of their spouse(s).

CONCLUSION

In conclusion, this study found that the level of male involvement in their partner's cervical cancer screening in Makueni County, Kenya was low, with only 18% of participants being actively involved. The findings indicated significant associations between male involvement and socio-demographic factors, socio-cultural and economic factors. These findings underscore the importance of enhancing health education and ensuring accessibility and availability of cervical cancer screening services to increase the level of male participation and the attendant benefit of increased support to their female partner's uptake of cervical cancer screening services. This should be a significant boost in the fight against the scourge of cervical cancer among females.

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