

Maternal and Child Well-being Programmes' factors as determinants of male-partners' level of participation in the programmes in Kiambu County, Kenya

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Abstract- International development platforms and commitments have expressed the need for male-partner participation in Maternal and Child Wellbeing (MCW) programmes pointing to the beneficial effects of their participation. Men have a clear role in decision making regarding their families' reproductive health, however their participation has remained low especially in Sub-Saharan Africa. Many factors could be implied for their low level of participation some of which are related to the programme policies and their implementation. In Kiambu County, Kenya, where this study was carried out, a low (3%) male partner level of participation in maternal and child well-being programmes (Kiambu County Strategic Plan for 2008-2012) was identified as a challenge to successful implementation of the programmes. There was no earlier study on factors that could be implied for the low male participation. This study sought to determine if there existed a significant relationship between the current maternal and child well-being programmes and the male partners' level of participation in the programmes in the County. To achieve this objective a cross-sectional analytical study involving 142 males partners to women consuming the MCW services at level four and level five health facilities in Kiambu County, Kenya, was conducted between February 2016 and May 2016. A male partner's level of participation index was used to determine high and low levels of participation in the programmes. The study collected primary and secondary data which were both qualitative and quantitative. Descriptive as well as empirical analytical techniques were used to test for significance of the relationship between MCW programmes and the male partners' level of participation. The findings of the study revealed a negative and significant relationship between the predictor variable (current maternal and child well-being programmes) and the outcome variable (level of male partner participation in the programmes). The study found that male-partners who had a negative perception towards the current maternal and child well-being programme policies and how they are implemented registered a lower level of participation compared to those who had a positive perception. The findings are important in guiding policy formulation in coming up with programmes that are male friendly. This may be done through involving male partners as key stakeholders during policy formulation in order to incorporate their special reproductive health needs. This participatory approach may be expected to

improve communication and decision-making processes leading to coming up with male friendly maternal and child well-being programmes. This approach may in the long run lead to increased male partner participation in the programmes and the subsequent improved consumption of the services and higher retention in the programmes of their female partners and infants. This may lead to reduction of maternal and infant morbidity and mortality rates in Kiambu County as well as the National rates. This will be a positive step to achieving the social goal in Kenya's Vision 2030 by shifting health care services from curative to preventive. This may also support a more economically productive female population and healthy infants. It will be a step towards achieving Sustainable Development Goal 3 on achieving Good Health and Well-being.

Index Terms- Maternal, child, morbidity, mortality, and well-being programmes

I. INTRODUCTION

Recent research at the global level has shown that responsibility for uptake and sustainability in uptake of maternal and child wellbeing (MCW) services is a responsibility for both female and male parents however in most of the cases it is looked at as a female's [40,41]. International development platforms and commitments have emphasised the need for male participation in the programmes considering the benefits associated with it and without which the programmes are doomed to fail [38, 28]. Globally, high maternal and infant mortality and morbidity rates have been associated with this low male partner support for their female partners [42, 24]. In developing countries most of which are in the Sub-Saharan Africa, infant mortality rate is estimated at 239/100,000 live births [3, 4]. Maternal and child well-being programme related factors such as institutional infrastructure[8], time the services are offered at the health facilities [36] as well as the behaviour of health care providers towards the males have been implied for their low level of participation [1]. The prevailing reproductive health programmes are a reflection of traditional organisation in maternal and child well-being programmes that were institutionalized as a women's sphere where male-partners were deliberately excluded [17, 18]. Little has changed in recent times

to accommodative men in terms of infrastructure, service delivery hours and accommodation of male special needs among others [5, 16]. Inadequate infrastructure at the health facilities discourages male partners who are unable to complete with their female partners and the infants for the available space [11, 19]. Men only clinics or men only times at the health facilities may help to reduce this congestion and as well as reduce time spent in seeking the services [10, 20]. Physical layout within which the services are offered such as inadequate sitting space and sitting arrangements discouraged male participation [12, 9]. Long waiting hours and service hours conflicted with male partners' income generating activities [27, 7]. Family oriented approaches to maternal and child health programmes may improve male partners' level of participation [33, 35]. Distrust in confidentiality of the health care providers during VCT also discouraged male-partner participation [22, 37]. Health care provider attitudes towards male partners who accompanied their female partners to the health facilities discouraged them from attending the services with their partners [13, 15]. Limited reproductive health service choices for men such as contraceptives, clinic service delivery hours and health facility attendance hours within the maternal and antenatal clinics was intimidating and unsupportive of the male's participation [6, 14]. Men's stoic nature is also a drawback to male partner participation in VCT because they deemed themselves healthy and in control of their health a factor that conflicted with the requirement that they seek health care and especially with their female partners [34, 21]. Maternal mortality rate in Kenya is 362/100,000 live births [25,26], while the infant mortality rate is 52/1,000 live births [29] while 26 /1,000 infants suffer malnutrition [31,32]. World Health Organisation [30] ranked Kenya in position 39th in the less than five deaths at the global level [39]. Most of these high maternal and infant morbidity and mortality rates in Kenya have been associated with insufficient consumption of the MCW services due to low support accorded them by their male partners [2]. In Kiambu County where the study was carried out, like of parts of Kenya, registered a low (3%) male-partner participation in the M CW programmes. This had been identified by the County Health care management as a challenge to successful implementation of the programmes in Kiambu County [23]. There was no evidence of a study conducted to determine factors that could be implied for this low male participation. This would guide policy formulation and programme implementation to limit barriers and strengthen facilitators to male participation. The aim of this study was to

determine the effects of maternal and child wellbeing programme factors on male partners' level of participation in the programmes in Kiambu County.

II. METHODOLOGY

The current study adopted a cross-sectional descriptive analytical design. The study was carried out in Kiambu County, Kenya. The study aimed at establishing existing relationships between the male-partner's level of participation in maternal and child well-being programmes and the effects of programme related factors. Kiambu County just like other Counties in Kenya register low level of male-partner participation in the programmes and this is considered as a challenge to successful implementation of the programmes. The study collected data on level of male-partner's participation in the programmes (dependent variable) and on the presumed predictor variables (the effects of the current maternal and child well-being programme policies and their implementation which were referred to as programmes related factors). The target population for the study were male-partners to female partners who were nursing babies aged five years and below and who were consuming the maternal and child wellbeing services at the health facilities in Kiambu County during the time of the study. Data were collected from one hundred and forty two respondents were introduced to the study by their female partners. The female partners had been selected systematically as they came to the health facilities with their infants to consume the services. Consenting female-partners were requested to introduce their male-partners, whose consent for inclusion into the study was also sought. Qualitative as well as quantitative data were collected for the study. The collected data were subjected to descriptive as well as empirical analysis to establish causal inferences about hypothesised relationships between dependent and independent variables. This helped in testing of the study hypothesis that... *there is no significant relationship between male-partners' level of participation in maternal and child well-being programme sin Kiambu County and the programme related factors*. The study helped to identify significant predictor variables that were implied for the low level of male-partners' participation in the programmes in the County.

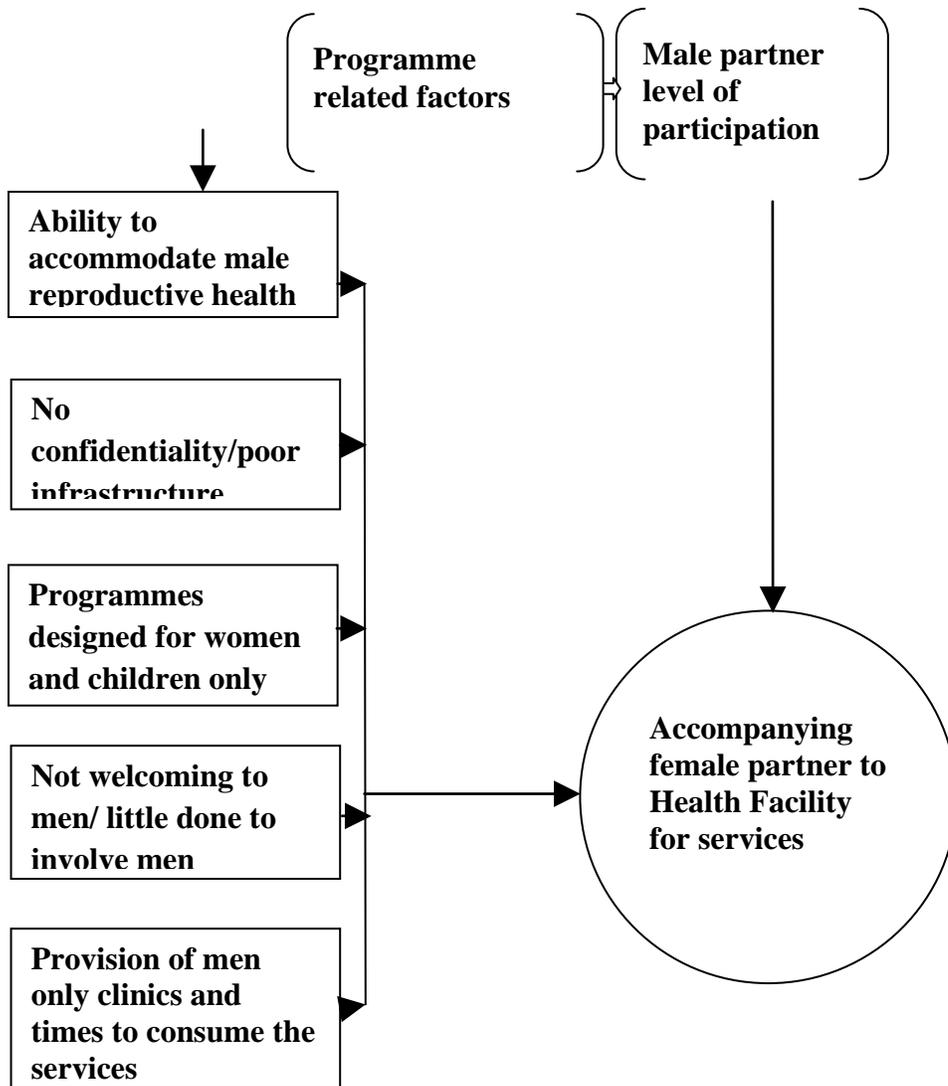


Figure 2 Conceptual framework

III. STUDY FINDINGS

The study findings revealed that maternal and child well-being programme related factors in Kiambu County had significant negative impact on the male partners' level of participation in the programmes. For instance, Chi-square test as used to test for independence of the male partners' level of participation in the programme against the predictor variables and the following findings were registered; the effects of male-partners' perception towards provision of men only clinics revealed ($\chi^2=90.54,df=1,p=0.000$), effects of male perception that health care providers were not welcoming to the male partners at the health facilities ($\chi^2= 109.4,df=1, p=0.000$), effect of the perception that the programmes were designed for women and children only ($\chi^2=38.55,df=1, 0.000$), effects of perception that

little has been done to welcome male-partners to the health facilities ($\chi^2 = 22.34,df=1,p=0.000$), effect of perception that the programmes were not accommodative to male reproductive health needs ($\chi^2= 40.901,df=1,p=0.000$), effect of perception that accompanying their female partner to the health facilities was consuming ($\chi^2 = 74.22,df=1,p=0.000$) and effects of the male perception that health facilities were inaccessible ($\chi^2= 74.22,df=1,p=0.000$). The Nagelkerke R^2 model for current programme related factors obtained a value of 0.928, which meant that programmes related factors explained 92.8% of the variation in male partner's level of participation in the programmes in the County.

Table 1: Summary model for effects of current maternal and child well-being programme related factors in Kiambu County

Model Summary	
-2 Log likelihood	21.535
Cox & Snell R Square	0.646
Nagelkerke R Square	0.928

Logistic regression for effects of programme related factors on male-partners’ level of participation in maternal and child well-being programmes in Kiambu County.

Logistic regression conducted on the collected data to test for the relationship between the male partner’s level of participation and the effects of programme related factors revealed a significant negative relationship; $y = (\alpha) 0.700 (-0.571)$. The probability (odds) of high level of participation (Table 2) was 4.88 times lower for male-partners who had the perception that the programmes were designed for women and children only compared to those who had a different perception and 5.75 times lower for male-partners who felt that health care providers were not welcoming to males who accompanied their female partners to the health facility compared to those who had a positive perception. Exp (B) column (the **Odds Ratio**) revealed that male-partners who agreed that health facilities offering

maternal and child well-being services are located far from home/work were 1.78 times less likely to register a high level of participation compared to those who disagreed. The probability (odds) of high level of participation was 5.50 times lower for male-partners who thought that the HFs did not provide confidentiality to the patients who went for HIV testing compared to those who felt that there was confidentiality. This negatively influenced their participation in couple VCT. The probability of high participation was 4.61 times lower for male-partners who felt that little had been done to accommodate male partners’ reproductive health needs compared to those who felt that their needs were taken care of.

Table 2. Logistic regression for effects of programme related factors on male-partners; level of participation

Table 2. Logistic regression for effects of programme related factors on male-partners; level of participation							
	B	S.E.	Wald	df	Sig.	Exp(B)	1/Exp(B)
Men Clinics(1)	1.142	0.266	18.432	1	0.000	3.133	
Unwelcoming(1)	-1.75	0.407	18.488	1	0.000	0.174	5.75
MCW designed For women children(1)	-1.586	0.499	10.102	1	0.001	0.205	4.88
Little done involve men(1)	-1.529	0.743	4.235	1	0.040	0.217	4.61
No confidentiality(1)	-1.704	0.553	9.495	1	0.002	0.182	5.50
	1.034	0.815	1.610	1	0.205	2.812	
Tested by nonresidents(1)	1.876	0.789	5.653	1	0.017	6.527	
Costly for two(1)	1.697	0.673	6.358	1	0.012	0.183	5.46
Costly for two(2)	-0.625	0.304	4.227	1	0.040	0.535	1.87
Time(1)	-1.124	0.478	5.529	1	0.019	0.325	3.08
Dugs)(1)	1.12	0.231	23.508	1	0.000	3.065	
Distance(1)	-0.576	0.261	4.870	1	0.027	0.562	1.78
Men be trained(1)	-1.996	0.832	5.755	1	0.016	0.136	7.36
Accommodate male health needs(1)	1.302	0.401	10.542	1	0.001	3.677	
Be attended by males (1)	1.849	0.636	8.452	1	0.004	6.353	
Constant	-1.155	0.275	17.640	1	0.000	0.315	3.17

The study findings implied a significant negative relationship between male-partners’ perception of the current maternal and child well-being programmes policies and their implementation versus their level of participation in the programmes. The hypothesis that male-partners’ perception of the current maternal and child well-being maternal and child well-being programmes policies and their implementation does not influence their level of participation in the programmes in Kiambu County was therefore rejected and the alternative hypothesis accepted. Current maternal and child well-being programme policies have in deliberately adopted historic institutionalisation of reproductive health services as a woman’s domain excluding male-partners through the institutional infrastructural organisation which have not changed to

accommodate male-partners. Service delivery hours and non-accommodation of male reproductive health needs have kept the male-partner a bay. In the recent past, emerging issues in reproductive health such as mother to child transmission of HIV have however created urgent need to accommodate the male-partner into the programmes. Male partners should be involved not as a passive facilitators for the female and infant health services but as an active constituent part of the programmes’ policy formulation and their implementation. The study found that majority of the male-partners who had the perception that the current maternal and child well-being programmes were not accommodative to the male special reproductive health needs registered a lower level of participation compared to those who felt that they were. This mean that male-partners’ negative

perception towards the programme policies and their implementation in Kiambu County had negative significant influence on their level of participation. The findings of the study portrayed that current programmes were unfriendly and unaccommodated to male-partner's special reproductive health needs which may have been a challenge in involving and sustaining male-partner participation in the programmes. For instance, there is a negative significant relationship between male partners' perception that health care providers are not welcoming to male-partners versus their level of participation. Male-partners were not allowed to join their female partners and the infants into the consultation rooms, which made their visit to health facilities loose meaning. Some healthcare providers were not welcoming to male-partners by being rude and even abusive a factor that discouraged further visits by the males. This made the male-partners perceive themselves as intruders into the women's and the infants' domain and opted to keep off. In other instances men seemed very inconsiderate, unkind and unreasonable if they sat down on seats while an expectant woman or a mother had lacked a seat due to inadequate infrastructure at the health facilities. This discouraged male partners who either walked out to wait for their partner outside or went away never to accompany their female-partner to the health facility again. The male-partners expressed optimism that the men only clinics or men only times for consuming the services would be less congested and they would spend little time at the health facilities. The facilities would be less noisy than the current situation and may attract more male-partners than the current situation. Majority of the respondents explained that during the day when the maternal and child wellbeing services were offered, most of the male-partners were busy with their economic activities causing conflict of interest. Long queues and long waiting hours at the health facilities mostly caused by limited number of days in a week when the services were offered also discouraged the male partners. This is compounded by long procedures they have to follow from payment queues, to training sessions, consultations and actual receiving of the services. The female-partners spend a whole day seeking the health services. Male-partners on the other had would become impatient and leave the female-partners to continue with the queues. The male partners who accompanied their female-partner during delivery also complained of not being allowed to accompany them to the wards during labour and delivery. The delivery rooms were treated as a feminine zone an aspect that discouraged male-partners from accompanying their female-partner to the health facilities during delivery.

The study revealed that during the postnatal clinics the healthcare providers paid attention to the mothers and the infants ignoring male-partners seemed mere escorts. This may explain why majority of the male-partners had accompanied their female-partner to the health facility only once or twice after which they stopped. The study found that majority of male-partners perceived themselves as intruders who added more workload to health facilities that were already overstretched by women and their infants. The study found that this perception contributed to the low level of male-partner participation in the programmes in Kiambu County. These findings imply a positive significant relationship between male-partners' perception that health care providers were not welcoming to the male partners and the outcome which is a low level of participation. These results also

imply a positive significant relationship between male-partners' perception that the programmes were designed for women and children only with little or no consideration for male partner and the subsequent level of participation. The study findings also revealed that there is significant relationship between male-partner perception that the health facilities were not confidential during VCT and the outcome level of participation during couple VCT.

The relationship between MCW programmes related factors and male-partner's level of participation in the programmes in Kiambu County was found to be significant and negative. These findings are important in guiding policy formulation in coming up with maternal and child well-being programmes that are male friendly. This may be done through involving male partners as key stakeholders during policy formulation in order to come up with policies that meet their special reproductive health needs. This participatory approach would be expected to improve communication and decision-making processes leading to male friendly maternal and child well-being programmes. This approach may in the long run lead to increased male partner participation in the programmes and the subsequent increased consumption of the services by their female partners and infants. This may eventually lead to reduction in maternal and infant morbidity and mortality rates in Kiambu County and also imply on the national level rates.

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