# FACTORS INFLUENCING THE INEFFECTIVE MALE INVOLVEMENT IN ANTENATAL CARE IN ISHAKA MUNICIPALITY, BUSHENYI DISTRICT, UGANDA

**OPIO JACOB**
**DCM 0160/143/DU**

**A RESEARCH REPORT SUBMITTED TO THE SCHOOL OF ALLIED HEALTH SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OFADIPLOMA IN CLINICAL MEDICINE AND COMMUNITY HEALTH AT KAMPALA INTERNATIONAL UNIVERSITY**

**JULY, 2017**

## DECLARATION

I, the undersigned, hereby declare that the work contained in this report is my own original work and has never been submitted to any institution or authority for any award or qualification. Where the works of others are quoted, appropriate reference has been given and acknowledged in the text.

**DCM 0160/143/DU**

SIGNED: ..... DATE: .....

**OPIO JACOB**

## APPROVAL

I certify that this research report under title “Factors influencing the ineffective male involvement in antenatal care in Ishaka municipality Bushenyi district, Uganda” has been written by the candidate under my supervision.

MR. KAIRANIA EMMANUEL

SIGNATURE: .....……. Date:……

## DEDICATION

This work is dedicated to the family of Mr Adolf Gabriel Owor. My God bless you all.

## ACKNOWLEDGEMENT

First and foremost, I thank the Almighty God for the providence, gift of life, knowledge and strength to accomplish this work.

I also wish to acknowledge and extend a debt of gratitude my supervisor, Mr.Kairania Emmanuel for the unwavering support and assistance during the time of report writing.

I wish to acknowledge all my friends and classmates, chief among them is NankyaLatifa. You continuously encouraged and supported me throughout the course and during study.

I am grateful to all the community members and leaders of Ishaka municipality for accepting to participate in the present study. May God bless you abundantly.

## TABLE OF CONTENTS

## ABBREVIATIONS

**ANC**: Antenatal care

**HC**: Health Centre

**HCW**: Health Care Workers

**HIV**: Human immune deficiency virus

**HW**: Health Workers

**KIU-TH** Kampala International University Teaching Hospital

**MCH**: Maternal Child Health

**MDG**: Millennium Development Goal

**MMR**: Maternal Mortality Ratio/Rate

**MOH:** Ministry Of Health

**MPI**: Male Partners Involvement

**Pg.**: Page

**PMTCT**: Prevention of Mother to Child Transmission

**Ref**: Reference

**SPSS**: Statistical Pack For Social Sciences

**STIs**: Sexually Transmitted Infections

**UBOS**: Uganda Bureau of Statistic

**UK**: United Kingdom

**WHO**: World Health Organization

## DEFINITION OF TERMS

**Maternal mortality rate:** Maternal death due to pregnancy related conditions per 100,000 live births.

**Antenatal care:** A planned methodical supervision of a pregnant woman to maintain her physical psychological and social wellbeing in order to achieve a full term pregnancy normal labour and with a live term baby.

**Perception:** A way of Regarding, Understanding, or interpreting something through seeing, hearing: a mental impression men Involvement.

**Perinatal death:** loss of foetus/infant between 20weeks of pregnancy to 1 month of age after birth

## LIST OF TABLES

## LIST OF FIGURES

## ABSTRACT

**Introduction:** Male involvement in antenatal care as one of the major aspects of maternal health care is an important strategy in reducing preventable maternal morbidity and mortality worldwide (Singh *et al*.,2012). Due to the low male involvement in antenatal care among other factors, the country continues to have one of the highest MMR at 137 per 1,000 live births (Tweheyo *et al*., 2010). Antenatal care visits are an ideal time to advise mothers with their partners and families on essential pregnancy care to reduce stillbirths and neonatal deaths and develop a birth preparedness plan (Lincetto *et al*., 2006).

**Methodology:** The researcher employed a quantitative cross sectional study design and the study population involved all married men or men who had ever had spouses in Ishaka municipality, Bushenyi district. Simple sampling technique was used. Data was collected using interview guided questionnaires formulated in English and subsequently analysed using SPSS 16.0. Data was then presented inform of tables, pie charts and graphs.

**Results:** One hundred and twenty males in Ishaka municipality participated in the study. The average age of the participants was 38.0 (SD ± 1.41) and age range was 17- 75 years. The majority of respondents 46(38.3%) were between the age of 35 and 44 years, 81 (67.5%). Banyankole .The majority of respondents 64(53%) have low levels of knowledge on male involvement in antenatal care. Commonly agreed barriers to male involvement included too much waiting time at the ANC,nature of spouses' occupation, fear of positive HIV results, long distance to ANC clinic,91(75%) ,80(66.7%), 68(56.7%), (51.7%) respectively. Enormous number 85(70.8%) of respondents agree that creation of awareness among men through traditional authorities can promote male involvement in antenatal care

**Conclusions:** This study concluded that, factors influencing male involvement in antenatal care included family Monthly income, distance from health, Alcoholism unit and level of knowledge of respondents. The majority of respondents had low levels of knowledge on male involvement in antenatal care.

Time wasting during antenatal visits was the commonest agreed barriers to male involvement during antenatal visit.

**Recommendation:** The study recommended the need to increase men's knowledge on male involvement in ANC through massive campaign in Ishaka municipality.

# CHAPTER ONE

## 1.0 Introduction

In this chapter, the researcher explains the background of the study, problem statement, study objectives, research questions, and significancse of the study

## 1.1 Background of the study

(USAID, 2009) defined positive male (husband) involvement in maternal health as the mental and physical participation of males (husbands) in maternal and prenatal health and family planning in such a way as to increase maternal and infant survival rates and improve family planning outcomes(Kululanga, Sundby, Chirwa, Malata, & Maluwa, 2012)

Globally, low male involvement in maternal health care services remains a problem to health care providers and policy makers. For many years, Reproductive Health (RH) issues focused on women in terms of Family Planning, Abortion, management of infertility, Sexually Transmitted Infections among others. Pregnancy and childbirth are privilege functions of women essential for the survival of our species but often accompanied by potential risks that women should be protected from, and this responsibility calls for collective support of the entire family notably the husband, the community and the state as a whole. This is according to SHAM-UNA UMAR("No Title," 2015).

Increasing male involvement in maternal health care is an important strategy in reducing preventable maternal morbidity and mortality worldwide (Singh *et al.*,2012).

In sub-Saharan Africa, approximately 69% of pregnant women receive at least one antenatal care (ANC) visit, and 44% receive at least four ANC visits and the full package of key interventions(Lincetto*et al.*, 2006).In Kenya 47% of pregnant women made the recommended four ANC visits (Onyango*et al.*, 2010). In Uganda, only 48% of mothers make at least four visits (UBOS, 2012).Despite the documented benefits of male involvement in ANC, in Uganda, male attendance at antenatal care is only around 10% (Tweheyo*et al.*, 2010) and male involvement is believed to be less than the national though not documented hence the need for this study to determine factors influencing male involvement in ANC so as to assist in laying strategies to improve their involvement.

## 1.2 Statement of the problem

Most cultures, especially in Africa, regard pregnancy and delivery as a female domain; therefore, men are often not expected to accompany their wives to the antenatal care (ANC) clinic or be present during delivery (Mullick, 2005). Men impact women's reproductive health through their role as partners, fathers and healthcare workers (Dudgeon *et al*., 2004)

There has been an increase in reproductive health initiatives that target both men and women in an attempt to fulfill the 5th Millennium Development Goal (Debra *et al*., 2014).However, male involvement has been low, and the lack of progress is a likely contributor to the sub-optimal advancement towards the achievement of the United Nations Millennium Development Goal (MDG) 5: to reduce maternal mortality by 75% between 1990 and 2015 (Kululanga*et al.*, 2011)

Despite the numerous documented benefits of male involvement in ANC, Gulu district and Uganda in general have low prevalence of male involvement in ANC with only 10% of male partners accompanying their wives either for ANC or delivery care (Tweheyo*et al*., 2010).Thus, to improve male participation in ANC, reasons for their poor or reluctant involvement need to be explored.

## 1.3 Study Objectives

### 1.3.1 General objective

To determine factors influencing the ineffective male involvement in antenatal care among men in Ishaka municipality, Bushenyi district, Uganda

### 1.3.2 Specific objectives

The following were the operational research objectives

- To determine men's knowledge on antenatal care
- To identify existing barriers to male involvement in antenatal care

## 1.4 Research questions

The study was guided by the following research questions

- What's the level of men's knowledge on antenatal care?
- What are the existing barriers to male involvement in antenatal care?

## 1.5 Significance of the study

The researcher anticipates the findings of the study to benefit the community especially men and women of Ishaka municipality in that it will improve on the practice of escorting partners

for antenatal care.This is because the researcher anticipates the information generated from the study to be used by the district health team to sensitize the community about male involvement in ANC.

The study has generated new research information which will be used as a reference source in medical research and as well increase on the existing body of knowledge.

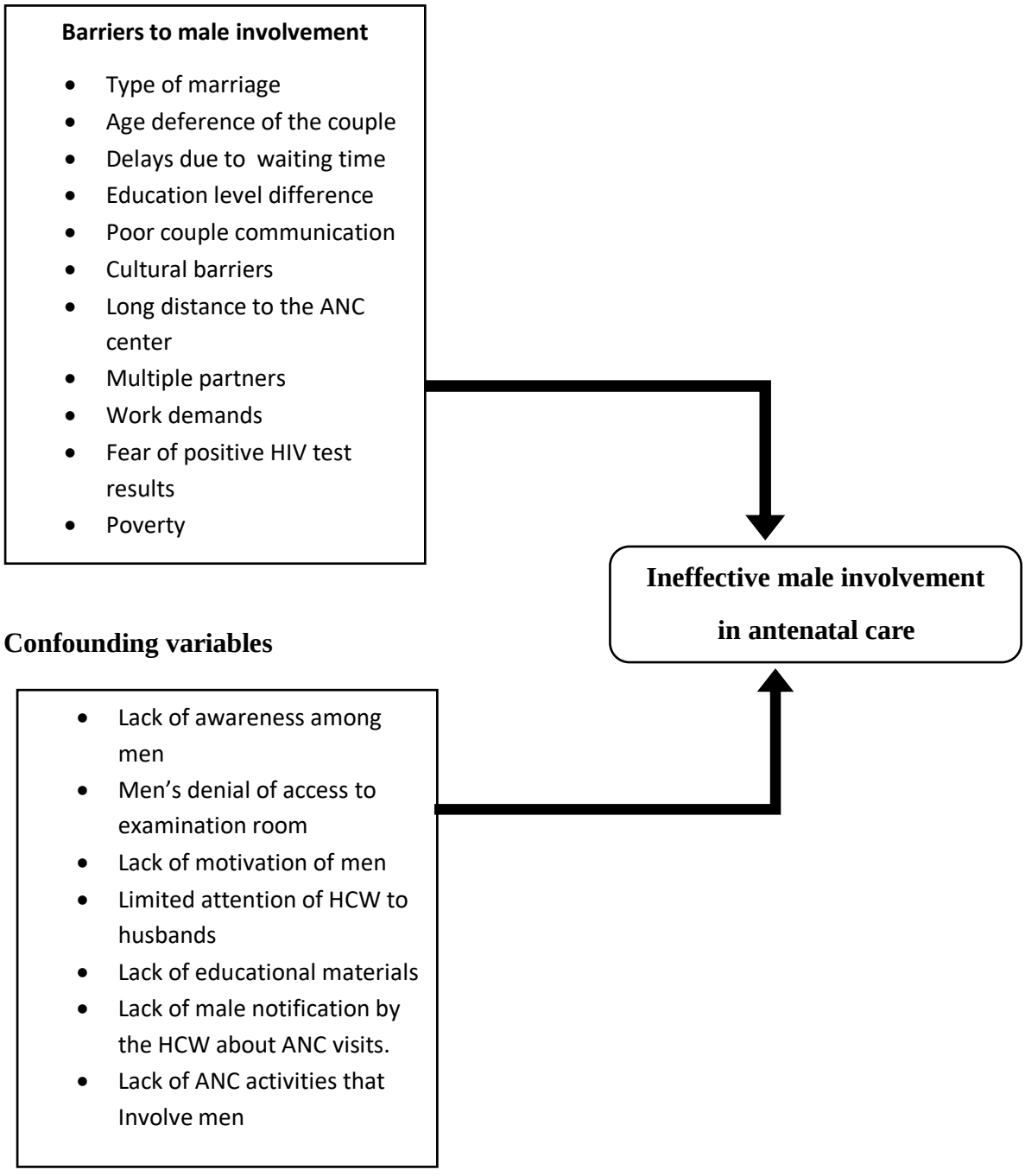
The study findings has also availed literature which will be used by planners in the ministry of health to strengthen health education and promotion programs to address areas of weaknesses with regards to male involvement in antenatal care. On the other hand recommendations being a basis for further research

**1.6 Scope of the study**

The study was designed to determine factors influencing male involvement in antenatal care among men in Ishaka municipality for a period of three month from April 2017 to June 2017. Males with wives or have ever married or are cohabiting and their partners have given birth to at least one child were eligible for the study. Males who are not residents of the selected study area and are in the study area and those that have not given birth to at least one child were excluded from the study.

## 1.7 Conceptual framework

**Independent variables** **Dependent variable**



# CHAPTER TWO

## LITERATURE REVIEW

### 2.0. Introduction

Review of the literature defines the process of researcher familiarizing with available information on the study topic (Christensen *et al*., 2011). Objectives of the study were narrated more in this chapter basing on stated specific objectives.

### 2.1 Men's knowledge on antenatal care

In a 2010 study conducted in Gulu district in Uganda by Mangeni*et al*., (2013), researchers found out that there is an association between male attendances at antenatal care and knowledge of antenatal care services. The study found out that one of the strongest factors was knowledge about antenatal care services. Furthermore the same study pointed out those men who knew more about antenatal care, had more drive to accompany their spouses (Mangeni*et al*., 2013).

Similar to Mangeni*et al*., 2013 study, also Sally *et al*.,(2013) study conducted in New Guinea revealed that knowledge about antenatal care also had an association (p+0.004) with male's ANC attendance. These findings were yet similar to studies from India and Nepal where men who received antenatal education provided better support to their wives, which led to increased ANC attendance and health facility delivery (Singh *et al*., 2009; Mullany*et al*., 2007).

Knowledge of the required number of ANC visits had the strongest associations with ANC attendance. In Kenya, a clear association was demonstrated between male attendance to at least one antenatal care visit and delivery by a skilled birth attendant (Bhatta*et al*., 2013) Men who knew the recommended number of ANC visits had almost a threefold increase in the odds of attending ANC compared to those who did not know (OR 2.75,95 % CI 1.89–4.01) (Wilunda*et al*., 2015).

### 2.2 Barriers to male involvement in antenatal care

Vast studies have reported about barriers to male involvement in antenatal care. A study done in Uganda identified perceptions such as pregnancy being a female role by most participants as an issue preventing them from accompanying their wives for either ANC or delivery care.

Men usually considered antenatal visits as the responsibility of mother-in-laws or co wives rather than for them (Debra *et al*., 2014).

Similarly in a study by Odimegwu*et al*., (2005), most men reported that their role in pregnancy was typically as providers, decision makers and extending practical help when their wives could not undertake the arduous domestic tasks allotted. Men reported they were too busy for such tasks, particularly as long queues meant delays and time wasting. (Theuring*et al*., 2009).Also according to Laura *et al*., (2015), work commitments was cited by one third of the women as the reason why their partner did not attend ANC.

Also negative attitude that HCWs had towards men participating in ANC or delivery care were among barriers mentioned. Most men reported that they had, or had heard anecdotally that other men had been ignored by HCWs, subjected to unfriendly attitude or even abusive language .Most men who had accompanied their wives for delivery similarly reported that maternity staff did not allow them to enter the delivery rooms; therefore, they choose to stay away feeling that they were not wanted there (Debra *et al*., 2014).Concurrent with study findings by Byamugisha*et al*., 2010, in which respondents also reported not allowing males to access ANC setting as a reason for not accompanying their spouses to antenatal clinic.

Financial constraints of clients and health facilities have been identified as impacting on health services uptake and male participation (Msuya*et al*., 2008; Nkuoh*et al.*, 2010). A Ugandan study reported that some health providers charged extra beyond the official ANC fees to bridge their own financial gaps (Byamugisha*et al*., 2010).with the extra charge, men decided to boycott ANC with fear of being charged more money.

In a study by Reece *et al*.,(2010), poor communication such as wrong ANC visit date between spouses was associated with poor male involvement. On the other hand, good couple communication was associated with support between husband and wife.

Studies have cited time wasting as a fundamental factor hindering male involvement in antenatal care. Men, who frequently are in the paid workforce, are often not in position to spend virtually the entire day participating in ANC services (Nkuoh*et al*., 2010)

Cultural standards were identified as barriers for male involvement (Nkuoh*et al.*, 2010.) Several studies have reported negative perceptions towards men attending ANC services. In one report, men who accompanied their wives to ANC services were perceived as being

dominated by their wives. Frequently men perceive that ANCs services are designed and reserved for women, thus men are embarrassed to find themselves in such “female” places (Mlay*et al*., 2008; Nkuoh*et al*., 2010).Certain women too, do not like to be seen with their male partners attending the ANC service since it’s a female role (Mlay*et al*., 2008). A study conducted in Kenya showed by Reece *et al*.,(2010) cultures such as giving birth by traditional healer formed an hindrance to male involvement in ANC since male clients tend to trust traditional healers more than hospital therefore do not attend ANC clinics (Reece *et al*., 2010).

# CHAPTER THREE

## METHODOLOGY

### 3.0 Introduction

This chapter discusses the study area, research design, study population, sample size determination and sampling techniques, instrumentation, data quality control and data processing that will be used for the study. It also presents the ethical consideration and probable study limitations.

### 3.1 Study area

The study was conducted in Bushenyi Ishaka town council Sub County in Bushenyi district. With a total population of 8,190 people, 3,963 males and 4227 females (UBOS, 2014). Major health centers in Bushenyi Ishaka town council are KIUTH and Ishaka Adventist hospital. The main economic activity in Bushenyi-Ishaka town council is majorly commercial businesses. However rearing cattle and growing crops like Bananas is practiced majorly for home consumption. The study area was selected because there are tremendous numbers of women attending antenatal care in the hospital within.

### 3.2 Research design and Rationale

The researcher used a quantitative cross sectional study design for this study. According to Amin (2005), a quantitative cross sectional study involves measuring different variables in the population of interest at a single point in time. The researcher used this design because it is cheap, quicker and avoids manipulation of variables (Amin, 2005).

### 3.3 Study population

The study population involved all married men or have ever had spouses in Bushenyi-Ishaka town council, Bushenyi district.

### 3.4 Sample size determination and Rationale

All the males in Bushenyi-Ishaka town council, Bushenyi district were selected for the study according to Krejcie and Morgan (1970) (*Appendix II*), for a population (N) of 3,963 males (UBOS, 2014), the sample size for the given population (S) is 246 respondents

### 3.5 Sampling technique and rationale

A two staged cluster simple sampling technique was used. In this study a cluster is a group of household in the same geographical area. A cluster was between 20 to 50 households. The cluster was selected in the first stage and respondents in the second stage. Firstly all parishes in the selected part of municipality and villages within the parishes were listed; one ward and one village were randomly selected from the selected part of municipality. If the village had less than 20 households, they were merged with neighbouring villages to make one cluster with between 20 to 50 households. Clusters were then selected using probability proportionate to the number of households. Household heads were interviewed within the cluster using interval sampling. Interview was started from the central part of the cluster and household heads selected randomly. This random sampling method was used because it avoids bias (Amin, 2005).

### 3.6 Inclusion and exclusion criteria

**3.6.1 Inclusion:**Males with wives or have ever married or are cohabiting and their partners had given birth to at least one child were eligible for the study.

**3.6.2 Exclusion:** Males who did not grant consent were ineligible for the study. Males who are not residents of the selected study area and are in the study area too, were ineligible for the study.

### 3.7 Data collection instruments

The researcher used a self-administered questionnaire formulated in English and translated into local language whenever necessary. It comprised of mainly three sections, A, B and C and D. The components of section A included the socio-demographic characteristics .On the other hand, the items of section B and C included both closed and open questions about the information of intended objectives.

### 3.8 Data quality control

To ensure validity and reliability of the tool, pre-testing was conducted in a different community which was not to be used in the actual study. After pre testing any variations identified were revised. This was done to ensure that the instruments were suitable to be used within this context thereby collecting data that met the expected objectives.

### 3.9 Data analysis and presentation

Data was edited, coded and entered in SPSS 16.0 for analysis. Presentation was done by use of tables, graphs and pie-charts.

### 3.10 Ethical consideration

The researcher was permitted by faculty of Allied health sciences of Kampala International University through the researchcoordinator. After permission was granted, the researcher submitted letters to village chairpersons of the selected areas of the various parishes in Bushenyi-Ishaka town council in Bushenyi district. After being granted permission, the researcher introduced himself to the heads of the various families for informed consent. The researcher ensured confidentiality of all the information obtained. The questionnaire was also identified using number so to ensure anonymity.

### 3.11 Study limitations

The researcher faced the following limitations during the course of the study:

The main limitation to the study was bias arising from participants wanting to provide socially desirable responses rather than true reflection of the real life situation.

In addition to the above, the time allocated for the research program was limited collecting due to the busy University schedule.

### 3.12 Dissemination of results

The study findings were disseminated to:

- The research committee faculty of AlliedHealth Science Kampala International University.
- The heads of community from which the study was conducted.
- A personal copy for future reference.

# CHAPTER FOUR

## PRESENTATION OF RESULTS AND INTERPRETATION

### 4.0: Introduction

One hundred and twenty (120) males in ward IV in Ishaka municipality participated in the study. The average age of the participants was 38.0 (SD ± 1.41) and age range was 18- 75 years.

### 4.1 Social demographic data of **respondents**

**Table 1: Showing the age groups of the respondents**

The majority of respondents 46(38.3%) were between the age of 35 and 44 years, 44(36.7%) were aged 25-34 years, 24(20.0%) were aged 45 years and above and lastly the minority 6(5%) were aged 18 to 24 years.

| **Age group** | **Frequency** | **Percentage (%)** |
|---|---|---|
| 18-24 | 6 | 5.0 |
| 25-34 | 44 | 36.7 |
| 35-44 | 46 | 38.3 |
| ≥45 | 24 | 20.0 |
| **Total** | **120** | **100.0** |

**Table 2: Showing tribe of respondents**

The lowest number of respondents 3(2.5%) belonged to other tribes, 12(10%) of the respondents were Batooro, and (24%) were Bakiga. The biggest percentage of respondents however constituted the Banyankole 81 (67.5%).

| **Tribe** | **Frequency** | **Percentage (%)** |
|---|---|---|
| Banyankole | 81 | 67.5 |
| Bakiga | 24 | 20.0 |
| Batooro | 12 | 10.0 |
| Others | 3 | 2.5 |
| **Total** | **120** | **100.0** |

**Occupation of the respondents**

**Table 3: Showing the occupation of the respondents**

The highest number of respondents 42(35.0%) were peasants followed by 38(31.7%) self-employed while civil servant, unemployed respondents made up 14(11.7%), 23(19.2%) respectively. 3(2.5%) were others such as students.

| **Occupation** | | **Frequency** | **Percentage (%)** |
|---|---|---|---|
| | Peasant | 42 | 35.0 |
| | self employed | 38 | 31.7 |
| | civil servant | 14 | 11.7 |
| | Unemployed | 23 | 19.2 |
| | Others | 3 | 2.5 |
| | **Total** | **120** | **100.0** |

**Bar graph showing frequency against education level of the respondents.**

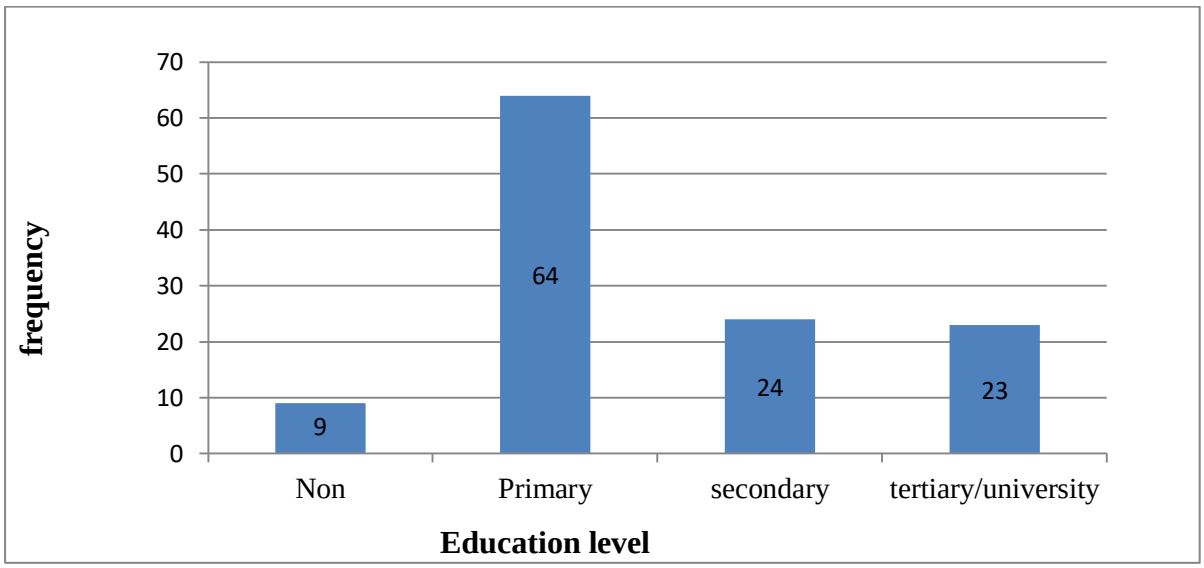



Figure 1**: Showing the education level of the respondents**

The majority of respondents 64(53.3%) had attained primary education, followed by 24(20.0%)) had attained secondary education, 23(19.2%) had attained tertiary/university education and the smallest number 9(7.5%) had never attained any level of education.

**Table 4: Showing the marital status of the respondents**

Substantial number of respondents 53(44.2%) were currently married, 25(20.8%) were cohabiting, 19(15.8%) were separated, 15(12.5%) were divorced and lastly 8(6.7%) were widowed.

| **Marital status** | **Frequency** | **Percentage (%)** |
|---|---|---|
| Divorced | 15 | 12.5 |
| Currently married | 53 | 44.2 |
| Widowed | 8 | 6.7 |
| Separated | 19 | 15.8 |
| Cohabiting | 25 | 20.8 |
| **Total** | **120** | **100.0** |

**Pie chart showing the religion of the respondents by percentage.**

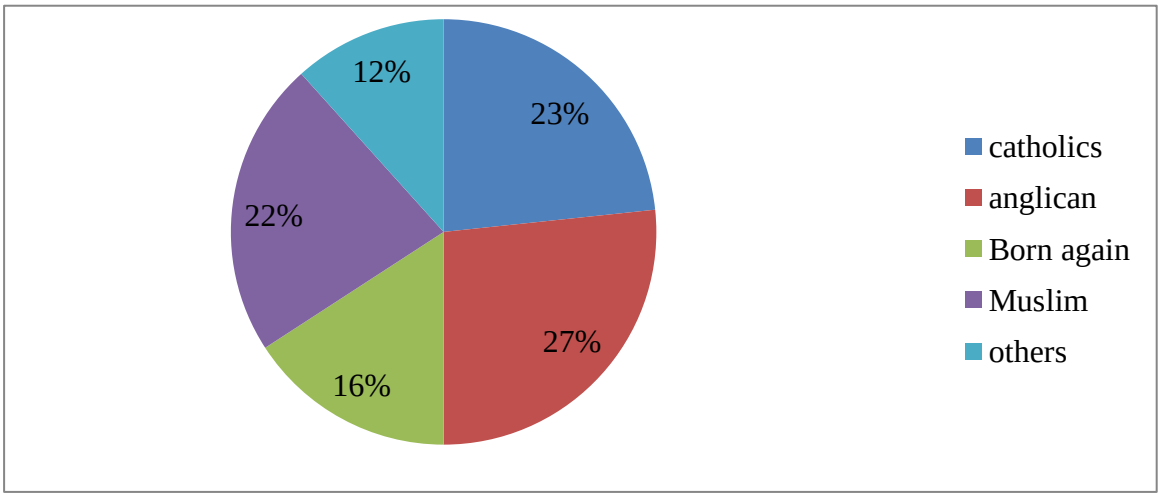



Figure 2**: Showing the religion of the respondents**

The majority of respondents 32(26.7%) were Anglican, 28(23.3%) were Catholics, 27(22.5%) were Muslims, 19(15.8%) were Born again and 14(11.7%) belonged to other religious denominations or did not have any religion.

**Table 5: crosstab analysis of social demographic factors**

| **Variable** | **Attending antenatal care with spouse (percentage)** | **Not attending antenatal care with spouse (percentage)** |
|---|---|---|
| **Age** | | |
| 18-24 | 8.0 | 2.9 |
| 25-31 | 46.0 | 21.0 |
| 32-38 | 30.0 | 31.0 |
| ≥39 | 16.0 | 22.9 |
| **Religion** | | |
| Catholic | 26.0 | 21.4 |
| Protestant | 18.0 | 32.9 |
| Muslim | 28.0 | 18.6 |
| Born again | 18.0 | 14.3 |
| Others | 10.0 | 12.9 |
| **Highest level of education** | | |
| <Secondary | 72.0 | 52.9 |
| ≥secondary | 28.0 | 47.1 |

| | | |
|---|---|---|
| **Marital status** | | |
| Currently Married | 38.0 | 48.6 |
| Divorced | 22.0 | 12.5 |
| Cohabiting | 18.0 | 22.9 |
| Widowed | 6.0 | 7.1 |
| separated | 16.0 | 15.7 |

### 4.2 Men's knowledge regarding their involvement in antenatal care

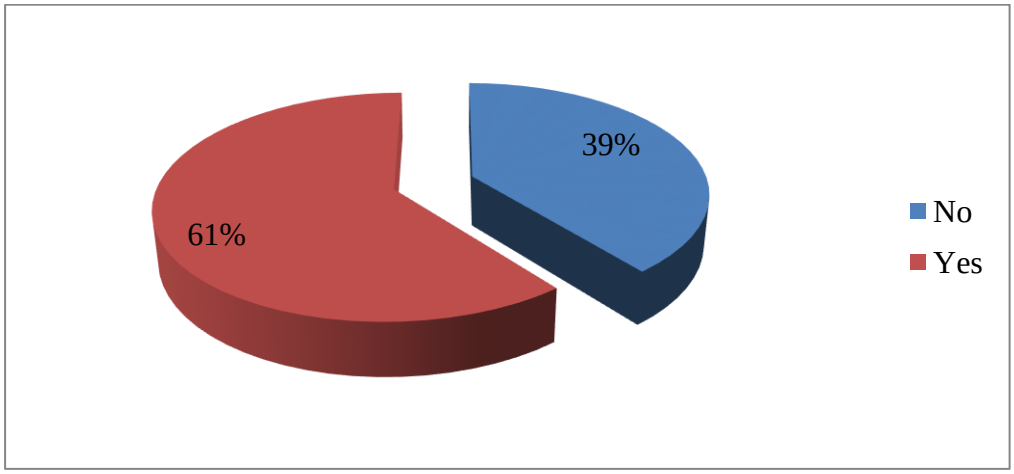



Figure 3**: Showing respondents who have ever heard about male involvement in the religion of the respondents**

The majority of respondents 73(61%) had ever heard about male involvement in antenatal care.47 (39%) had never heard about male involvement in antenatal care.

**How respondents basically understood male involvement in antenatal care.**

Of the 73 respondents who have ever heard about male involvement in antenatal care,23(31.5%) understood male involvement as men accompanying their wives for antenatal visits.39(53.4%) did not suggest anything pertaining their understanding about male involvement in ANC.11(15.1%) had other ideas how they understood male involvement in ANC.

**A bar chart of frequency against source of information about male involvement in antenatal care.**

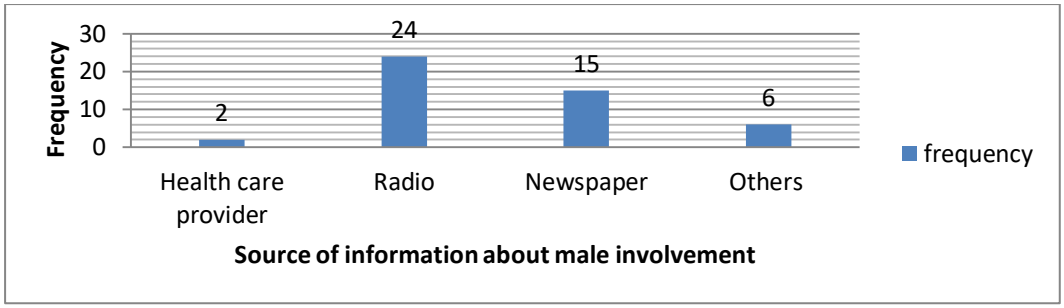



Figure 4**: Showing Source of information about male involvement in antenatal care**

Of the 73 respondents who had ever heard about male involvement in antenatal care, the majority 37(51.1%) reported hearing about it from Radio talks, 23(31.9%) reported hearing about it from Newspapers, 8(12.7%) reported other sources such as public talks while the minority 5(6.8%) reported their sources as health care providers.

**Pie chart showing benefits of male involvement in ANC**

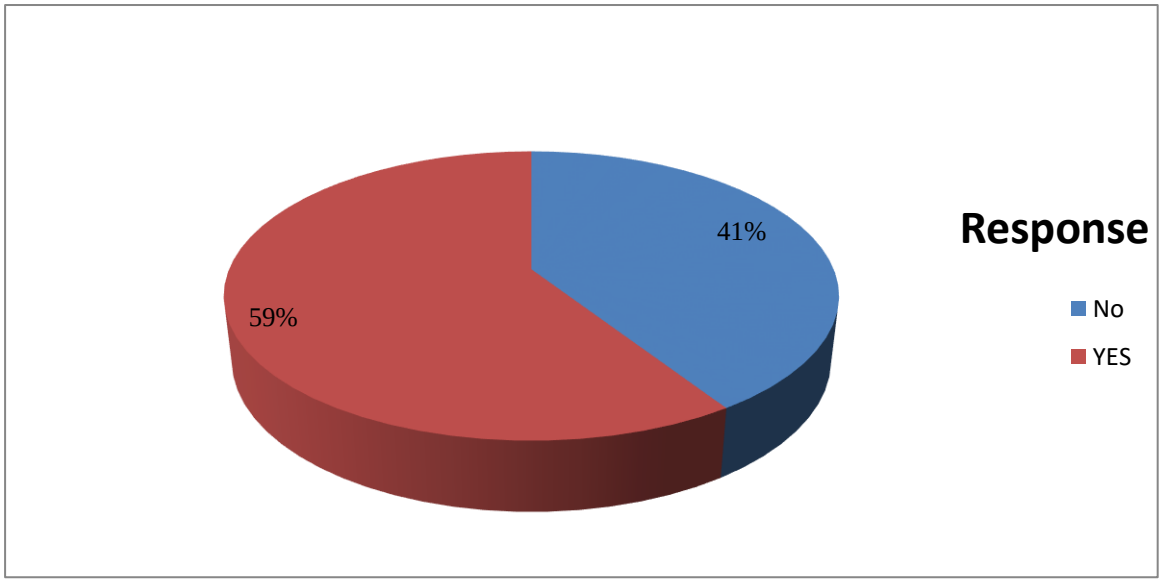



Figure 5**: showing whether Male involvement in ANC is beneficial**

The majority of males 71(59%) conceded that male involvement in antenatal care is beneficial while 49(41%) of males conceded that male involvement in antenatal care is not beneficial.

**Postulated benefits of male involvement in ANC by respondents**

Interestingly, the majority participants 71(59%) in Ishaka Municipality reported that it was beneficial to accompany their wives for ANC. seven of the 71 respondents suggested that

men getting involved in ANC is a good way to know what's going on with their spouses ."When you are with her it shows contact, you are aware of what is going on there and in case of any complications or even if any referral might be needed, you may decide on what you can do"

Other participants (5 of the 71) postulated that male involvement in ANC strengthens love between their spouse and them.

''Attending together shows the love l have for her since we are together in all circumstances of life''

Some men (3 of the 71 respondents) report discovering their spouse HIV status as merit of getting involved during antenatal visits

"If I go with her to the clinic, we can be tested and get out of there knowing our status of HIV

''If one person is positive and another negative then we can be told how to stay together."

**Reasons why respondents believe male involvement is irrelevant.**

A few of respondents (12 of the 49 respondents) view pregnancy and childbirth as women's responsibility and as such they per take work as more beneficial to them than involving in antenatal care.

"Pregnancy and rearing of children are women's affair therefore most young men are only interested in making babies."

Some respondents (8 of the 49 respondents) propounded that they do not learn when they attend ANC since they are not allowed to access examination rooms. As such they would rather remain at home or do other duties. "It's of no use for me to escort my wife for antenatal care when am going to learn anything from the health unit."

A trifle of respondents(2 of the 49 respondents) consider male involvement in antenatal care as culturally disrespectful for a man to see a woman giving birth and as such there is no benefit since one is crossing lines with ancestors.

"In our culture pregnancy and child birth is for women, our fathers were not involved in pregnancy issues"

Enormous number of respondents (18 of the 49 respondents) believes involving males in antenatal care is waste of money and time

"Male in involvement in antenatal care is a waste of time and money since my spouse alone can handle"

### 4.3 Barriers to male involvement in antenatal care

**Table 8: showing barriers to male involvement in antenatal care**

The majority 80(66.7%) of respondents agree that the nature of spouse occupation may serve as a barriers, 26(21.6%) of respondents disagreed that nature of spouse occupation may serve as a barriers to male involvement in ANC.14 (11.7%) respondents neither agree nor disagree that nature of spouse occupation may serve as a barriers to male involvement in ANC.

The majority 68(56.7%) of respondents agree that Fear of positive HIV test results can bar Men from escorting their wives for ANC.42 (35.0%) disagree that Fear of positive HIV test results bars Men from escorting their wives for ANC.10 (18.3%) of the males neither agree nor disagree that Fear of positive HIV test results can bars Men from escorting their wives for ANC

The majority74(61.7%) of respondents agreed that poverty can makes men not to escort their partners.24(20.0%) disagree that that poverty can makes men not to escort their partners. The minority 22(18.3%) neither agree nor disagree that poverty can makes men not to escort their partners

The majority 91(75%) of respondents agree that too much waiting time at the ANC visit can hinder some men from going together with their wives for ANC.19 (15.9%) of the respondent disagree that too much waiting time at the ANC can hinder some men from going together with their wives for ANC.10 (8.3%) of respondents neither agree nor disagree that too much waiting time at the ANC can hinder some men from going together with their wives

The majority62(51.7%) of respondents agree that long distance travelled by couples may hinder men from escorting their wives.39(32.5%) of respondents disagree that that long distance travelled by couples may hinder men from escorting their wives. The minority 19(15.8%) of respondent neither agree nor disagree that long distance travelled by couples may hinder men from escorting their wives.

Substantial number 57(47.5%) of respondents agree that culture in some societies bars some men from escorting their partners for health care services 52(43.3%) disagree that Culture in some societies bars some men from escorting their partners for health care services.19(9.2%) of respondents.

| Statement | Response Frequency (percentage) | | | |
|---|---|---|---|---|
| | **Agree** | **Disagree** | **Neither agrees or disagree** | **Total Frequency (%)** |
| Monogamous can act as barriers to male involvement to attending ANC | 15(12.5) | 68(56.7) | 37(30.8) | 120(100) |
| Polygamous too can act as a barrier | 67(55.8) | 11(9.2) | 42(35.0) | 120(100) |
| Having many patients may make males relax from accompanying their wives | 49(40.8) | 46(38.4) | 25(20.8) | 120(100) |
| Nature of spouse occupation may serve as a barriers | 80(66.7) | 26(21.6) | 14(11.7) | 120(100) |
| Fear of positive HIV test results bars Men from escorting their wives for ANC | 68(56.7) | 42(35.0) | 10(18.3) | 120(100) |
| Poverty Makes Men not to escort their partners | 74(61.7) | 24(20.0) | 22(18.3) | 120(100) |
| Nature of marriage such as cohabiting, polygamous may make men not to escort their partners | 21(17.5) | 29(24.2) | 70(58.3) | 120(100) |
| Age different of couples maybe a barrier to escorting their partners | 26(21.7) | 44(36.6) | 50(41.7) | 120(100) |
| Too much waiting time at the ANC hindering some Men from going together with their wives | 91(75.8) | 19(15.9) | 10(8.3) | 120(100) |
| Bad language used by mid wives makes men fear to escort their partners | 45(37.5) | 23(19.2) | 52(43.3) | 120(100) |
| Education level differences of spouses may be a barriers for them to move together | 29(24.2) | 40(33.3) | 51(42.5) | 120(100) |
| Poor communication between | 41(34.2) | 30(25.0) | 49(40.8) | 120(100) |

| | | | | |
|---|---|---|---|---|
| couple may be a barrier for them to move together for ANC services | | | | |
| Culture in some societies bars some men from escorting their partners for health care services | 57(47.5) | 52(43.3) | 11(9.2) | 120(100) |
| Long distance travelled by couples may hinder men from escorting their wives. | 62(51.7) | 39(32.5) | 19(15.8) | 120(100) |

# CHAPTER FIVE

## DISCUSSION, CONCLUSION AND RECOMMENDATION

### 5.0 Introduction

This chapter focused on the discussion of the study findings, conclusion and recommendation.

### 5.1 Discussion

Male involvement in reproductive health improves health outcomes, particularly in regards to family planning, antenatal care, and the prevention of mother-to-child transmission of HIV. Men play a role in their partners' reproductive health experiences in multiple ways, from shared decision-making or granting permission for certain services to providing financial support and transport for health services. The average age of the participants was 38.0 (SD ± 1.41) and age range was 18- 55 years. The majority of respondents 46(38.3%) were between the age of 32 and 38 years followed by 44(36.7%) who were aged 25-31 years.

The highest number of respondents 42(35.0%) were peasants followed by the self-employed while civil servants and unemployed respondents made up 14(11.7%) and 23(19.2%) respectively. 3(2.5%) were others such as students.

The majority of respondents 64(53.3%) had attained primary education, followed by 24(20.0%)) who had attained secondary education. 23(19.2%) had attained tertiary/university education and the smallest number 9(7.5%) had never attained any level of education.

Substantial numbers of respondents were married followed by respondents who were cohabiting. The current finding is contrary to a report by UBOS (2011) in which the majority 49.0% of residents were never married and only 8.8% of residents were married UBOS (2011).

Generally the majority of respondents were Christians as depicted by table 1. This Result from table 1 may be attributed to Christianity being the first religious denomination to be introduced in Uganda by the missionaries.

Generally, in regard to the knowledge of respondents on male involvement in ANC, the researcher graded the respondents into three categories basing on the number of questions answered: men with high level of knowledge on male involvement in ANC ought to have answered 7-10 of the questions correctly, those with moderate knowledge ought to have answered between 4-6 questions correctly and those with low knowledge ought to have answered less than four of the questions correctly. With reference to this grading, the

majority of respondents (53%) had low levels of knowledge on male involvement in antenatal care, a substantial number 43(36%) of respondent had moderate levels of knowledge on male involvement in antenatal care and the minority 13(11%) had high levels of knowledge on male involvement in antenatal care. This finding is in consonance with a study by Tweheyo*et al*., (2010) in Gulu district in which knowledge about safe motherhood services among male partners was limited with only 47.1% knowing 3-5 services offered at ANC. Also another study finding which is in consonance with the current study in which only 19.2% of respondents had attained higher level of education is a study by Joelle *et al*., 2014 in which men with low education level had significantly lower Knowledge Scores compared to men with high level of education.

According to the current study finding, vast numbers of respondents 73(61%) have ever heard about male involvement in antenatal care. This could be due to the on-going campaign aimed at promoting male involvement in HIV/AIDS and STI prevention.

Of the 73 respondents who have ever heard about male involvement in antenatal care, a trifle of respondents 23(31.5%) understood male involvement as men accompanying their wives for antenatal visits whereas 53.4% of respondents had no idea pertaining their understanding about male involvement in ANC. This finding could be due to illiteracy or less use of social media to enlighten the community members about male involvement in ANC.

Of the respondents who had ever heard about male involvement in antenatal care, the majority of participants 24(51.1%) report hearing about it from Radio talks. Others included Newspapers and public talks .This finding could be due to most respondents having radios at home compared to other sources such as newspapers.In similar study by Alinane*et al*., 2013 most respondents heard about ANC and PMTCT through radio messages, adverts, and motivational talks.

Interestingly, some participants (59%) in Ishaka Municipality conceded that it was beneficial to accompany their wives for ANC. The suggested merit included getting to know what's going on with their spouses and involving in decision making such as signing consent for surgery. Other respondents believe male involvement in ANC strengthens love between them and their spouses. Furthermore some respondents reported discovering their spouse's HIV status as a merit of getting involved during antenatal visits. Other respondents saw getting involved in antenatal care as a way of getting first-hand information about the health of their wives and unborn babies.

Of the 41% of the respondents who conceded that male involvement in ANC is irrelevant. A bevy of the respondents (12 of 49) view pregnancy and childbirth as women's responsibility as such they per take work as more beneficial to them than involving in antenatal care. This current study finding is concurrent with Byamugisha*et al*., 2010 that reiterate this finding. In their findings, frequently men perceive ANC services as designed and reserved for women, thus they are embarrassed to find themselves in such "female" places

"*Everyone has his or her role to play in the family*"

A few respondents (8 of the 49) propounded that they do not learn anything when they attend ANC since they are not allowed to access labour or examination rooms. As such they would rather remain at home or do other duties.

"The doctors do their things behind closed door and leave me in suspense at the end of the day"

A trifle of respondents (2 of the 49 respondents) considers male involvement in antenatal care as culturally disrespectful to men. "There are better things a man can do rather than lowinghimself to escort his wife" This finding is in consonance with Msuya*et al*., 2006 in which men who accompanied their wives for ANC services were perceived as being dominated by their wives Msuya*et al*., 2006.

Enormous number of respondents (18 of the 49) believes involving males in antenatal care is a waste of money and time.

"I would rather do other precious activities since it makes no difference to escort my wife for check-up"This finding is concurrent with a study by Byamugisha*et al*., 2010 in which Men considered attending antenatal together as a waste of time. (Byamugisha*et al*., 2010)

Time wasting during antenatal visits was one of the commonly agreed barriers to male involvement during antenatal visit. The majority of males reported they were too busy for such tasks, particularly as long queues meant delays in being seen and too much time wasted during the antenatal visits. Most men in paid work forces prioritized their time on economic activities and those without on farming. Similar findings have been reported in other studies (Theuring*et al*., 2009; uzochukwu*et al*., 2010; Byamugisha*et al*., 2010). Possibly men can be encouraged to attend ANC by opening antenatal clinics on Saturdays-Sunday when most men who are in paid jobs are home. However many of the local population in this current study are subsistence farmers which may limit their attendance.

The majority of respondents agreed that the nature of spouse occupation may serve as barriers to male involvement in ANC. Other authors have agreed with this study finding (Reece *et al*., 2010; kowalczyk*et al*., 2002; Byamugisha*et al*., 2010).

The majority of respondents in the current study agreed that financial constraints of men can hinder their participation in ANC.This finding is similar to several other studies in which financial constrain is reported as a barrier to male involvement ANC (Reece *et al*., 2010; Msuya*et al*., 2008; Theuring*et al*., 2009; Nkuoh*et al*., 2010).

Respondents in the current study commonly agreed that fear of receiving an HIV positive result can prevent males from coming for antenatal services together with their spouses. This is concurrent with many studies in which males were mentioned to be concerned about HIV associated stigma and disclosure Reece *et al*., 2010; Ndiaye*et al*., 2009; Sprague*et al*., 2011). In other studies in which respondents were women, they mentioned discovery of a positive HIV status as leading to violence, abandonment, rejection or being perceived by their spouses as being responsible for bringing HIV into the couples' relationship (Mangeni*et al*., 2013; Ntaganira*et al*., 2008). In contrast, Tweheyo*et al*., 2010 study in Uganda revealed that men were more likely to accompany their spouses for ANC if there was voluntary counselling and HIV testing services offered during the visits. Therefore, it is important, during the initial ANC attendance and any community health education, to ensure that men in the community understand that HIV counselling and Testing is voluntary. Furthermore, discussing HIV test result with the partners, encouraging partners to be supportive regardless of the HIV test results and encouraging male participation in couple counselling and willingness to accompany their spouses for ANC could be of benefit in reducing the fear of receiving an HIV positive result.

Another barrier stemmed from long distance travelled by most couples to the health centres for ANC .Several studies also reveal lack of transport and long distance to ANC clinics as a barrier to men escorting their wives for ANC (Tann*et al*.,2007;Van Eijk*et al*.,2006;KNBS,2011).

Substantial number of respondents in the current study agreed that culture can bar some men from escorting them from attending ANC with their spouses. In this current study, Some men believed that its culturally disrespectful for a man to see his wife giving birth, others echoed that their spouses need privacy during antenatal visits while others considered escorting their spouses for ANC as a foreign practice. This finding is concurrent with vast study findings in

which culture hindered males from involving in antenatal care. (Kwambai*et al*., 2013; oboro*et al*., 2011; Reece *et al*., 2010; Mlay*et al*., 2008)

## 5.2 Conclusion

Factors influencing male involvement in antenatal care included family monthly income, distance from health centres, heavy alcoholism and level of knowledge of respondents.

The majority of respondents had low levels of knowledge on male involvement in antenatal care.

Time wasting during antenatal visits was the commonest agreed barrier to male involvement in ANC. Others included nature of spouse occupation, financial constraints, fear of receiving an HIV positive result and long distance travelled by most couples

## 5.3 Recommendation

- There is need for health education to increase men's knowledge on male involvement in ANC through mass campaign in Ishaka Municipality.
- There is need for government to set up more health centres in the rural areas.
- Massive sensitization of the masses in ishaka against the dangers of alcoholism.

## References


Amin, M. (2005). *Social Science Research: Conception, Methodology and Analysis.* Kampala: Makerere University Printery.

Baiden F, Remes P, Baiden R, Williams J, Hodgson A, Boelaert M, Buve A.(2005).*voluntary counselling and HIV testing for pregnant women in the Kassena-Nankana district of northern Ghana: is couple counselling the way forward*? AIDS Care, 17:648–657

Bhatta DN: *Involvement of males in antenatal care, birth preparedness, exclusive breastfeeding and immunizations for children in Kathmandu,* Nepal.(2013). BMC Pregnancy Childbirth, 13:14.

Byamugisha R, Tumwine JK, Semiyaga N, Tylleskär T.(2010): *Determinants of male involvement in the prevention of mother-to-child transmission of HIV programme in Eastern Uganda: a cross-sectional survey*. Reproductive Health, 7:12.

Christensen, L.B, Johnson, R.B & Turner, L.A. (2011). *Research Methods, Design, and Analysis.* (11th Ed). Pearson

De Schacht C, Ismael N, Santos I, Calú N, Vubil A, Alons (2011): *HIV incidence during pregnancy and post-partum period in Southern Mozambique:* impact on vertical HIV transmission. Rome: 6th IAS Conference on HIV Pathogenesis and Treatment and Prevention; Abstract no. MOPE124.

Debra Singh, May Lample and Jaya Earnest.(2014). *The involvement of men in maternal health care: cross-sectional, pilot case studies from Maligita and Kibibi, Uganda* Reproductive Health, 11:68.

Ditekemena J, Matendo R, Koole O, Colebunders R, Kashamuka M, TshefuA,Kilese N, Nanlele D, Ryder R .(2011): *Male partner voluntary counselling and testing associated with the antenatal services in Kinshasa, Democratic Republic of Congo: a randomized controlled trial*. Int J STD AIDS , 22(3):165–170.

Ditekemena john, Olivier Koole2, Cyril Engmann3, Richard Matendo4, Antoinette Tshefu4, Robert Ryder and Robert Colebunders.(2012). *Determinants of male involvement in maternal and child health services in sub-Saharan Africa*: a review. Reproductive Health, 9:32.

Dudgeon MR, Inhorn MC.(2004): *Men's influence on women's reproductive health:* medical anthropological perspectives.59(7):1379–1395.

Duff P, Kipp W, Wild TC, Rubaale T, Okech-Ojony J.(2011*): Barriers to male partnerinvolvement in PMTCT programmes and HIV testing:* a need for more

malefriendlyservices, 6th IAS Conference on HIV Pathogenesis and Treatment and Prevention. Rome. Abstract no. CDC031.

Ediau M, Wanyenze RK, Machingaidze S, Otim G, Olwedo A, Iriso R.(2013).*Trends in antenatal care attendance and health facility delivery following community and health facility systems strengthening interventions in Northern Uganda.* BMC Pregnancy Childbirth.13:189.

Gourlay A, Birdthistle I, Mburu G, Iorpenda K, Wringe A. (2013) *Barriers and facilitating factors to the uptake of antiretroviral drugs for prevention of mother-to-child transmission of HIV in sub-Saharan Africa:* a systematic review. J Int AIDS Soc;16:18588.

Jennings L, Na M, Cherewick M, Hindin M, Mullany B, Ahmed S.(2014) *Women's empowerment and male involvement in antenatal care: analyses of Demographic and Health Surveys (DHS) in selected African countries.*BMC Pregnancy Childbirth;14:297.

Joelle I Rosser, Jennifer M Zakaras, Sabina Hamisi and Megan J Huchko.(2014) *Men's knowledge and attitudes about cervical cancer screening in Kenya*. BMC Women's Health 14:138

Kebaabetswe PM. (2005): *Barriers to participation in the prevention of mother-to-child HIV transmission program in Gaborone, Botswana a qualitative approach*. AIDS Care, 19(3):355–360.

Kevin P Hanretty Obstetrics Illustrated 6thed Sixth edition 2003chapter 5 pg 65-69.ISBN 0443 07267 1 Reprinted, 2004.

Kowalczyk J, Jolly P, Karita E, Nibarere JA, Vyankandondera J, Salihu H.(2002):*Voluntary counselling and testing for HIV among pregnant women presenting in labour in Kigali, Rwanda.* J Acquire Immune DeficSyndr, 31(4):408–415.

Kululanga LI, Sundby J, Malata A, Chirwa E.(2011): *Striving to promote male involvement in maternal health care in rural and urban settings in Malawi - a qualitative study*. Reprod Heal, 8:36.

Laura F. Jefferys1, Philo Nchimbi2, Paulina Mbezi2, Julius Sewangi and Stefanie Theuring.(2015) *Official invitation letters to promote male partner attendance and couple voluntary HIV counselling and testing in antenatal care: an implementation study in Mbeya Region, Tanzania*. Reproductive Health : 12:95.

Lincetto O, Mothebesoane-Anoh S, Gomez P, Munjanja S. (2006): Antenatal Care: Chapter 2.Inopportunitiesforafrica'sNewborns.http//www.who.int/pmnch/media/publications/aonsection

Mangeni JN, Mwangi A, Mbugua S, Mukthar V.2013): *Male involvement in maternal health as a determinant of utilization of skilled birth attendants in Kenya*. DHS Working Papers.published by Usaid: extracted from https://www.dhsprogram.com/publications/-WP93-Working-papers.

Mlay R, Lugina H, Becker S.(2008): *Couple counselling and testing for HIV at antenatal clinics:* views from men, women and counsellors. *AIDS Care*, 20:356–360.

MoH, 2012.*Uganda clinical Guidelines: National guidelines for management of common conditions.* Obstetric and Gynaecological conditions: 352-534.

Msuya SE, Mbizvo E, Hussain A, Uriyo J, Sam NE, Stray-Pedersen B.(2006)*: HIVamong pregnant women in Moshi Tanzania: the role of sexual behavior,male partner characteristics and sexually transmitted infections.* AIDS ResTher , 3:27.

Msuya SE, Mbizvo EM, Hussain A, Uriyo J, Sam NE, Stray-Pedersen B.(2008): *Low male partner participation in antenatal HIV counselling and testing in northern Tanzania: implications for preventive programs*. AIDS Care ,20(6):700–709.

Mullany BC, Becker S, Hindin MJ.(2007).*The Impact of including husbands in antenatal health education services on maternal health practices in urban Nepal*: results from a randomized controlled trial. Med Health Edu Res, 22(2):166–176. doi:10.1093/her/cy1060.

Mullick S, Kunene B, Wanjiru M.(2005): *Involving men in maternity care: health service delivery issues, Agenda Special Focus*.124–135.

Nkuoh GN, Meyer DJ, Tih PM, Nkfusai J.(2010)*: Barriers to men's participation in antenatal and prevention of mother-to-child HIV transmission care in Cameroon, Africa. J Midwifery Woman's Health*, 55(4):363–369.

Ntaganira J, Muula AS, Masaisa F, Dusabeyezu F, Siziya S, Rudatsikira E.(2008): *Intimate partner violence among pregnant women in Rwanda.* BMC Woman's Health, 8:17.

Odimegwu C, Adewuyi A, Odebiyi T, Aina B, Adesina Y, Olatubara O, Eniola F.(2005) *Men's role in emergency obstetric care* in Osun State of Nigeria. Afr J Reprod Heal 2, 9(3):59–71

Onyango MA, Owoko S, Oguttu M.(2010): *Factors that influence maleinvolvement in sexual and reproductive health in western Kenya: a qualitative study*. Afr J Reprod Heal, 14(4 Spec no.):32–42.

OrnellaLincetto, SeipatiMothebesoane-Anoh, Patricia Gomez, Stephen Munjanja.(2011) *antenatal care Opportunities for Africa's New-borns chapter 2*:51-61.

Reece M, Hollub A, Nangami M, Lane K.(2010): *Assessing male spousal engagement with prevention of mother-to-child transmission (PMTCT) programs in western Kenya*. AIDS Care, 22(6):743–750.

*ruralahmadnagao,* India. Population Review 2009,48 (1):83–102. 010.1353/prv.0.0016.

Sally Kura, John Vince and Paul Crouch-Chivers. (2013). *Male involvement in sexual and reproductive health in the Mendi district, Southern Highlands province of Papua New Guinea:* a descriptive study Reproductive Health,10:46.http://www.reproductive-health-journal.com/content/10/1/46.

Semrau K, Kuhn L, Vwalika C, Kasonde P, Sinkala M, Kankasa C, ShutesE,Aldrovandi G, Thea DM.(2005): *Women in couples antenatal HIV counselling and testing are not more likely to report adverse social events*. AIDS, 19:603–609.

Singh A, Ram F. (2009).*Male involvement during pregnancy and child birth: evidence from*

Singh K, Bloom S, Haney E, Olorunsaiye C, Brodish P.(2012).*Gender equality and childbirth in a health facility*: Nigeria and MDG5. Afr J Reprod Health 2012,16(3):122–128.

Tanzania Commission for AIDS.(2013)Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS.

Theuring S, Mbezi P, Luvanda H, Jordan-Harder B, Kunz A, Harms G.(2009): *Male involvement in PMTCT services in Mbeya Region, Tanzania*. AIDS Behav, 13:92–102.

Titus K Kwambai, Stephanie Dellicour, Meghna Desai, Charles A Ameh, Bobbie Person, Florence Achieng, Linda Mason, Kayla F Laserson and Feiko O terKuile.(2013) *Perspectives of men on antenatal and deliverycare service utilisation in rural western Kenya*: a qualitative study. BMC Pregnancy and Childbirth, 13:134

Tweheyo R, Konde-Lude J, Tumwesigye NM, Sekandi JN.(2010): *Male partner attendance of skilled antenatal care in peri-urban gulu district, northern uganda.*BMC Pregnancy and child birth,10(23):Retrieved from http://www.biomedcentral/1471-2393/10/53/.

UBOS, (Uganda Bureau of Statistics), ICF International Inc.(2012). Uganda demographic and heath survey 2011.available form

UBOS, 2014 *population by sex by Sub County by 2014.National population and housing census 2014* retrieved from www.bushenyi .og.ug/district/statistics

United Nations: *Report of the Fourth World Conference on Women.* 4-15 Sept

WHO, UNICEF, UNFPA, World Bank, UN. (2014).*Trends in maternal mortality:* 1990 to2013 Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Geneva: WHO.

WHO, UNICEF, UNFPA,WorldBank,UN.(2014) *Trends in maternal mortality: 1*990 to2013 Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Geneva.

WHO.(2011): *Global HIV/AIDS response Epidemic update and health sector progress towards Universal Access, Progress Report 2011.* Geneva: World Health Organization. http://www.who.int/hiv/pub/progress_report2011

WilundaCalistus , GianlucaQuaglio, Giovanni Putoto, Risa Takahashi, Federico Calia, DesalegnAbebe, Fabio Manenti, DonataDalla Riva, Ana PilarBetrán and Andrea Atzori.(2015). *Determinants of utilisation of antenatal care and skilled birth attendant at delivery in South West Shoa Zone, Ethiopia:* a cross sectional study. Reproductive Health 12:74

# APPENDICES

**Appendix i: participant consent form**

Dear Participant,

I ‘am Opio Jacob, a student at Kampala International University pursing Diploma in clinical medicine. I am conducting a study to determine factors influencing male involvement in antenatal care among men in Ishaka, Bushenyi district, Uganda. The researcher hopes that the findings of this study will increase the knowledge and awareness of the community about male involvement in Antenatal care. The data from this study will be published in the form of thesis. It is likely that portions will be used in subsequent academic publications. However, no individual answers will be exposed; all the information provided will be kept confidential. To try to achieve confidentiality and anonymity, do not write your names on the questionnaires. Your participation is voluntary and if you do not want to take part in the study, you are free not to. No one will penalize you if you refuse to participate. Please feel free to respond genuinely and if you decide to withdraw from the study any time after its commencement, you won’t be stopped. As a volunteer to the study, you are requested to sign the attached consent section below.

I have read and understood the description provided above. I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above; I understand that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

Participant’s signature/Thumb print ----------

Date……

**Appendix ii: questionnaire for respondents**

**(a) socio-demographic characteristics**

1. **Village/ Address** ----------

**2. Age of respondents**

a) 15-24 [ ] 25-34 [ ] 35-44 [ ] ≥45 [ ]

**3. Tribe of respondent**

Munyankole [ ] b) Mukiga. [ ] c)Muganda [ ] others specify [ ]

**4. Religion of respondent**

Catholic [ ] Protestant [ ] Muslim [ ] Born again [ ] Others (specify)……

**5. Occupation of respondent**

a) Self-employed [ ] Civil servant [ ] Peasant farmer [ ] e) others (Specify)……

**6. Educational level**

a) Primary [ ]b) Secondary [ ]c) Tertiary. [ ] d) None [ ]

**7. Marital status of respondent**

a) Married [ ]b) Cohabiting [ ]c) Divorced [ ]d) Separated [ ]e) Widowed [ ]

**B) Men's knowledge regarding their involvement in maternal child health services.**

**1. Have you ever heard of male involvement in antenatal care?**

a) Yes ( ) b) No ( )

**2. If yes what is it?**.....

**3. Where did you hear it from?**

a) Health facilities ( ) Radio ( ) Newspapers ( ) Othersspecify ...( )

**4. What services that could determine couple involvement**

**a) Testing together for HIV ant other STDs**

Yes ( ) No ( ) I don't know ( )

**c) Receiving counseling as couple on Diet, hygiene**

Yes ( ) No ( ) I don't know ( )

**d) To be told to avail everything the wife wants**

Yes ( ) No ( ) I don't know ( )

**e) Drawing both care plan together**

Yes ( ) No ( ) I don't know ( )

**5) Is male involvement in ANC beneficial?**

Yes ( ) No ( )

**6. Give reasons for your answer. If your answer was yes or No in 5 above**

**……**

**C) Barriers to male involvement in antenatal care**

Please tick the appropriate choice in statement that you believe in to be acting as barrier to male involvement in antenatal care.

Thank you for your participation

**Appendix III: The Krejcie and Morgan (1970) table for sample size determination from a given population**

| N | S | N | S | N | S | N | S | N | S |
|---|---|---|---|---|---|---|---|---|---|
| 10 | 10 | 100 | 80 | 280 | 162 | 800 | 260 | 2800 | 338 |
| 15 | 14 | 110 | 86 | 290 | 165 | 850 | 265 | 3000 | 341 |
| 20 | 19 | 120 | 92 | 300 | 169 | 900 | 269 | 3500 | 246 |
| 25 | 24 | 130 | 97 | 320 | 175 | 950 | 274 | 4000 | 351 |
| 30 | 28 | 140 | 103 | 340 | 181 | 1000 | 278 | 4500 | 351 |
| 35 | 32 | 150 | 108 | 360 | 186 | 1100 | 285 | 5000 | 357 |
| 40 | 36 | 160 | 113 | 380 | 181 | 1200 | 291 | 6000 | 361 |
| 45 | 40 | 180 | 118 | 400 | 196 | 1300 | 297 | 7000 | 364 |
| 50 | 44 | 190 | 123 | 420 | 201 | 1400 | 302 | 8000 | 367 |
| 55 | 48 | 200 | 127 | 440 | 205 | 1500 | 306 | 9000 | 368 |
| 60 | 52 | 210 | 132 | 460 | 210 | 1600 | 310 | 10000 | 373 |
| 65 | 56 | 220 | 136 | 480 | 214 | 1700 | 313 | 15000 | 375 |
| 70 | 59 | 230 | 140 | 500 | 217 | 1800 | 317 | 20000 | 377 |
| 75 | 63 | 240 | 144 | 550 | 225 | 1900 | 320 | 30000 | 379 |
| 80 | 66 | 250 | 148 | 600 | 234 | 2000 | 322 | 40000 | 380 |
| 85 | 70 | 260 | 152 | 650 | 242 | 2200 | 327 | 50000 | 381 |
| 90 | 73 | 270 | 155 | 700 | 248 | 2400 | 331 | 75000 | 382 |

Note: "N" is **population size** "S" is **sample size**

**Appendix iii: Map of Bushenyi district showing the counties, Sub Counties and parishes**

**Appendix iv: Map of Bushenyi-Ishaka showing parishes**