FACTORS ASSOCIATED WITH LOW MALE INVOLVEMENT IN MATERNAL CHILD HEALTH SERVICE UTILIZATION IN IGANGA MUNICIPAL COUNCIL

BY

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DECLARATION

I **Balwanyi Charles** a student of Kampala International University hereby declare that the work is original and is out of my own effort except where otherwise stated and has not been submitted to any University or institution for any other award.

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Date...11-12-2014.....

APPROVAL

This research report was written under my supervision and submitted with my approval.

Name of supervisor: Odoki Martin BSC, MSC

Signature..... Date..11/12/2014.....

DEDICATION

I dedicate this research report to my mother Mrs Nairuba Robinah, my brother Andrew Ngobi Sage and all my other brothers and sisters.

ACKNOWLEDGEMENT

I would like to thank God the Almighty for the gift of life and the wisdom to do this work.
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
FP	Family Planning
HC	Health Centre
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
MCH	Maternal Child Health
MDGs	Millennium Development Goals
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
RH	Reproductive Health
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendants
TM	Traditional Medicine
UDHS	Uganda Demographic Health Survey
UNFPA	United Nations Population Fund
VHT	Village Health Team
WHO	World Health Organization

ABSTRACT

Male involvement is necessary for the increase in the utilization of maternal child health services by the mothers and the pregnant women. The aim of the study was to establish the factors associated with low male involvement in maternal and child health services in Iganga municipality. It also was aimed aimed at establishing whether economic, socio-cultural factors, lack of knowledge and the level of male involvement in Iganga municipality are responsible for low male involvement in maternal child health services.

It was descriptive cross sectional study carried out in Iganga municipality in Iganga district and it involved 115 males ever married participants and they were selected using the simple random sampling method.

Cultural factors and traditional belief emerged as factor leading to low male involvement since most of the respondents agreed

Lack of knowledge and adequate information about maternal child health services by the male was a major contributing to low male involvement in the municipality.

Being very busy at work, long line of mothers waiting for MCH services, lack of knowledge on whether the men are supposed to be in hospital with their spouses, unemployment or low income of the family and male superiority where all viewed by the men as the factors leading to low male involvement.

Escorting the wives to the hospital and providing essential support were viewed as the main ways of male involvement and it was high above the national level which was good.

The municipality together with the ministry of health should raise awareness by an intensive community mobilization and sensitization about the responsibility of men in maternal child health services.

Also we need to encourage all families to have income generating projects such that they may have stable incomes to facilitate the man and the woman to attend MCH services together.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background.

At the 1994 International Conference on Population and Development (ICPD) in Cairo the participating nations (179) agreed on the action plan, which stated that "Changes in both men's and women's knowledge, attitudes and behavior are necessary conditions for achieving a harmonious partnership between men and women. This would open doors to gender equality in all spheres of life , including improving communication between men and women on issues of sexuality and reproductive health and improving understanding of their joint responsibilities" (UNFPA, 2004).

The focus of Reproductive Health (RH) and family planning (FP) shifted to women as its clientele, making male involvement peripheral or leaving boys and men out of the programs all together (Aceng, 2011). Boys and men, are the decision makers in many countries in Africa and play a dominant role in couples' fertility decisions, family size and other significant issues related to Sexual and Reproductive Health needs and Rights (SRHR), were no longer active participants in SRHR/FP/HIV programs (Aceng,2011). It was soon realized by UNFPA that little progress was being made with RH/FP/HIV programs and that neglecting boys, men and their sexual and reproductive health needs and rights causes adverse consequences, not only for the boys and men, but also for girls, women and children. However, the responsibility for nurturing children in the homes has for long been largely left to women including immunization, seeking health care and feeding the children (Aceng, 2011). The support of boys and men was very crucial in promoting the use of contraceptive, maternal and child health, prevention and control of HIV, thus contributing to health life styles of men, women and children.

Involving men in SRHR programs is particularly challenging in Uganda, which has many ethnic groups with diverse cultures, customs and taboos that define male gender. These culturally defined gender roles may hinder men's participation. For example, in most communities communication between couples is limited and manifestations of masculinity often involve

violence against women. Involving men in SRHR in such settings is complicated and demands a long term commitment; yet, the rewards could be profound. There are many interpretations of male involvement ranging from 'accompanying couple services' to male corners. However, accompanying should not be an end in it self, but part of an integrated package relevant to men. Male involvement should include the invisible issues that that take place in the home and should put into consideration all support roles. The rewards of male involvement will be profound and include the following:

Realization of women's sexual and reproductive health and rights, improve child and maternal health, better communication between partners, joint and informed decision making in households and improved family health.

1.2: Statement of the problem.

Males play big roles in decision making of matters concerning there spouses and the family as a whole. They are also the main financers of the family and so can determine on which activity will be carried out in a home on a particular day. In 2008/9 financial year, only 47%of the women in Iganga attended ANC the recommended four times, supervised deliveries were only 63% while only 77%of the women who delivered in the health facilities attended postnatal care at least once 6 weeks following delivery(Iganga district HMIS 2008/9). So its believed that the low uptake of maternal child health services by the mothers is because they are not supported by there husbands financially, morally and above all they are not escorted to the health facility by there spouses for MCH services and this as resulted in low utilization of maternal and child health services which has in turn led to a high maternal and infant mortality rates of the country. Currently, Iganga district health services offers invitation cards to every pregnant woman inviting the partner /husband to attend ANC and discuss issues related to pregnancy of her wife, childbirth and postnatal care. Secondly, first priority is given to mothers who have come for ANC and PNC with their partners/husbands. There is also Village Health Teams (VHTs) which are functional in some of the sub counties in the district and the one of the roles of VHT is to mobilize and disseminate information concerning maternal health services (Nantumu,2012).

Despite these efforts by the district health managers, the male involvement in ANC, delivery and postnatal care services still persists to be low and perceived barriers to male involvement in maternal health care services in the district are not well understood.

1.3.0: Objectives of the study

1.3.1: General objective

To establish the factors associated with low male involvement in maternal child health service in Iganga municipality.

1.3.2 : Specific objectives

i. To determine economic factors affecting male involvement in maternal child health services in Iganga municipality.
ii. To assess the knowledge of men regarding maternal child health services in Iganga municipal council.
iii. To determine the social cultural factors that are responsible for low male involvement in maternal child health services in Iganga municipal council.
iv. To determine the level of male involvement in maternal child health services in Iganga municipality.

1.4 Research Questions

1. What are the economic factors that affect male involvement in MCH services in Iganga municipality?
2. Does lack of knowledge about MCH services affect male involvement in Iganga municipality?
3. What are the social cultural factors that affect male involvement in MCH services in Iganga municipality?
4. What is the level of male involvement in Iganga municipality?

1.5: Scope of the study.

1.5.1 Geographical scope

The study was carried out in Iganga municipal council in Iganga District in the Eastern Uganda along the Jinja-Tororo highway. There is a hospital, two HC IIIs and three HC IIs.MCH services are provided in the hospital and health centre IIIs.

1.5.2 Time scope

The study mainly focused on the period between 2010 and 2013and the target population were men who are married or have children and stay in Iganga municipal council. The study ran for three months, starting in September, 2014 to November, 2014.

1.5.3 Content scope

The study mainly focused on what social, economic factors that can lead to low male involvement and it also assessed the knowledge and attitude of the men about male involvement.

1.6 Justification of the study

Male involvement includes male responsibilities and participation as a critical aspect of improving Reproductive Health outcomes, achieving gender equality, equity and empowering the women. Male involvement is critical in the reduction of maternal and infant mortality and morbidity in Uganda (Uganda male involvement strategy 2011).

This means that male involvement in maternal child health services of their spouses will increase the utilizations of ANC, delivery services and postnatal care services in the health facilities since the males are the decision markers and providers or financers of the women. And this in turn will lead to decreased complications to the mothers, increased survival of the children and there mothers hence reducing the expenditure of the family, district and the country on MCH services. It will also provide an opportunity to the men to be diagnosed and treated of sexually related diseases hence improving their health. This study will contribute to the drawing avenues of which may bring the males on board henc reducing the maternal mortality and morbidity of the country.

The potential benefits of men's involvement include realization of rights for women, improved family heath, better communication between couples and joint and informed decision making

within house holds, better utilization of sexual and reproductive health services such as delivery in health units, PMTCT, screening for cancers of the reproductive organs and an overall improvement in the health of women and children. However, this will definitely improve the health of men as well. This increase in service utilization should lead to improved health outcomes and the realization of the targets for MDGs 4 and 5.

1.7: Significance of the study

World over, every pregnancy faces an element of risk. Men, as partners and decision markers, need to be involved in maternal health services. Low male involvement in maternal health care services results low utilization of ANC, delivery and postnatal care leading to *high* morbidity and mortality. A man accompanying their wives in routine ANC and other maternal health services is an important factor in contributing the reduction of maternal morbidity and mortality.

To the community the study will increase the utilization of MCH services, improve the family health, help the women to realize there sexual and reproductive health and rights. It will foster joint and informed decision making in house holds and above all better the communication between the partners.

To science, this study is going to bring the two partners together during this crucial time and this will help the scientists to make the right diagnoses and give the right treatment and this will result in complete healing of sexually transmitted infections and other diseases hence reduced maternal and child mortality rates in the country.

1.8: Conceptual frame work

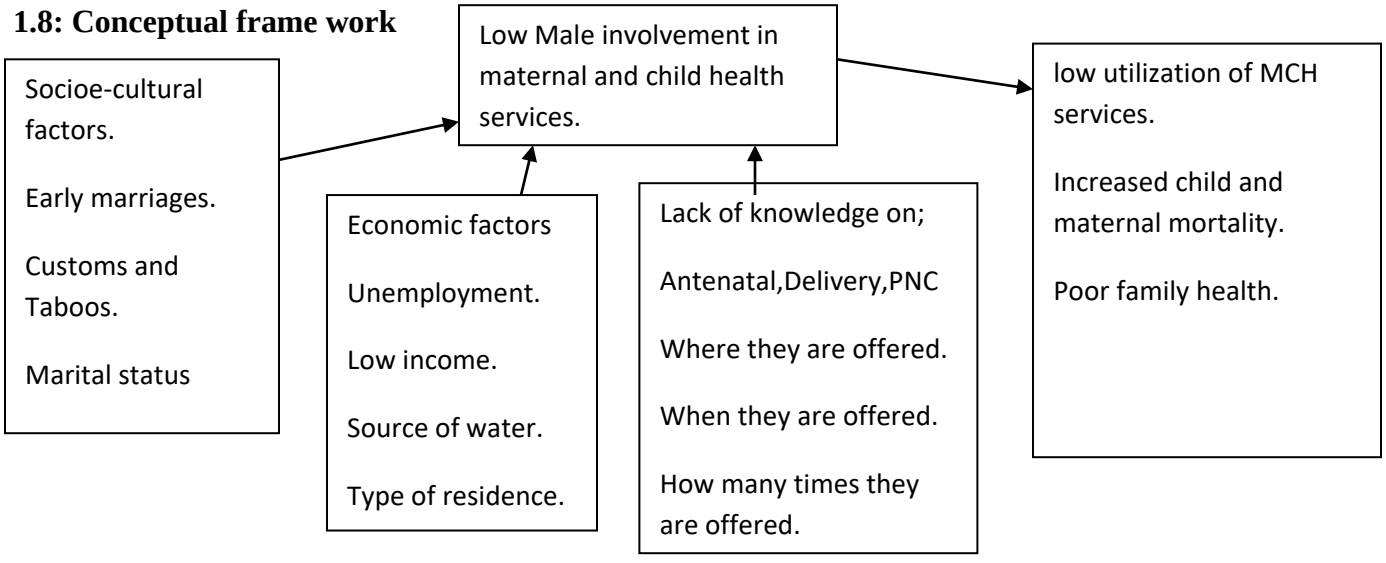

Figure 1: shows how the different factors lead to low male involvement.

In the above frame work it is clear that so many factor affect male involvement in maternal and child health services in Uganda. Low or lack of knowledge about male involvement by the pregnant women themselves and also the partners. Socioeconomic factors, health facility related factors have been viewed as independent factors that can lead or cause low male involvement in maternal and child health services. And if there is low male involvement then it will lead to low utilization of MCH services, increased child and maternal mortality, poor family health and failure of the female to realize their sexual reproductive health and rights.

CHAPTER TWO

2.0 LITERATURE REVIEW

Globally, low male involvement in maternal health services remains a problem to health care providers and policy makers. Since the Cairo International Conference on population and development (ICPD) 1994, and the Beijing World conference for women 1995 a lot of emphasis has been to encourage male involvement in reproductive health including maternal health. The Beijing conference emphasized that man's attitudes, knowledge base and ways of reacting influences not only men's health but also women's reproductive health (WHO, 2007).

Since the Cairo International Conference on population and development (ICPD Program of Action, 1994), global recognition of the importance of men's involvement in Sexual and Reproductive Health and Rights (SRHR) has increased. Issues such as AIDS epidemic have reinforced the urgency of encouraging men to take responsibility for their own sexual and reproductive health and that of their partners (Salem, 2004). Despite the global recognition at the level of international agreements, many countries have not developed large scale programs that reach out to men. As a result, many men are not aware of why they need to be involved in SRH, how they can get involved, and what services are available for them and their partners.

It is widely recognized that men are often marginalized by the maternal health care provided with limited access to basic information and knowledge to help them make an informed decision and choice in order to promote their own health as well as that of their families (Ntabona, 2002). Koisa (2002) reported that most men do not actually accompany their partners to the antenatal care consultations or during labor or delivery. These seem to agree with (Cigdem *et al.*,1999) who reported that in Turkey ,it was observed that health workers were not supporting men who wanted to join in maternal health services. The same study also noted that a lot of men come to the clinic with their wives but they are stopped at door.

The husband is often the primary decision maker and wife's economic dependence on her husband gives him greater influence on major house hold decisions, as was reported in Nepal by Britta and others (2004) where 50%of the women had the final decisions about their own health care made by their husbands (Nepal demographic and health survey, 2001). The above study

agrees with the one of Pagel *et al.,* (1990) and Mutale *et al.*,(1991) who concluded that lack of social support especially from husband and family has negative effects on the fetal growth.

A study in Nepal by Britta *et al.,* (2004) revealed that husbands accompanied only 40%of their women attending ANC for the first time and that greater decision making power for women was associated with lower husband accompaniment to overall male involvement. Men do not seek health information and services due to notions of masculinity where asking for help from a nurse or doctor is viewed as a sign of weakness. Many men feel it is their right to refuse contraception, to allow their partners or even discuss FP (Engender Health, 2008). These refusals can lead to unwanted pregnancies, unsafe abortions and maternal death or disability.

Britta *et al., (*2004) in their study done in Nepal, concluded that higher women autonomy was associated with lower male involvement in pregnant health.

Muwa *et al.*,(2008) noted that part of the reason for the low male involvement have come long way with the traditional attitude of health workers, coupled with notices in the health care premises for example "men are not allowed in the labor ward" which discourage men from giving support to their wives in ANC and labor. And in that very context (WHO, 2001) noted the tendency of health providers and researchers in the field of reproductive health who focus exclusively on women when planning programmes and services with regard to family planning (FP),prevention of unwanted pregnancies and of unsafe abortions and promotion of safe motherhood.

The situation is worsened by the fact that information received from health workers on maternal health care is primarily aimed at women as was reported by UNFPA (1999) in several developing countries that women not men were the targets of reproductive health programmes yet most of them are not financially or culturally positioned to make decisions about these issues without consulting their husbands. This could also be a matter of policy as noted by Greene *et al.,* (2002), that researchers and reproductive health service providers have tended to describe the women's disadvantaged positions without men's roles. This has resulted in some reproductive health programs designed to improve women reproductive health to consider men as part of the problem and no part of the solution.

In order for African countries to achieve the millennium development goal 5 of reducing maternal mortality by three quarters by 2015 requires a 5.5% annual average reduction of maternal mortality. However the actual reduction for Sub Sahara Africa between 1990 and 2005 was only 0.1% (WHO, 2008).This slow progress in reducing maternal mortality is a result of a number of factors including lack of maternal health services and some cases where services exist some husbands have been reported to refuse their wives to seek maternal health services.

Studies show that there is a general lack of interest on the part of the men in some countries in Africa in their partners` reproductive health (WHO, 2005). Men often do not have access to information on maternal health issues and on their role in promoting maternal health into majority of the men not to have sufficient information and knowledge with regard to maternal health.

Young and kol (1999) also noted that in Zimbabwe, most men misinterpreted the campaign messages promoting male involvement to mean that decisions should solely be left to men. Sometimes couple dialogue may breakdown for reason or the other and the whole family function fails and yet the mother has to come to health facility for MCH services .It will be hard for the husband to cooperate in such a scenario. Relatedly, Kasolo and Ampaire (2000) highlighted an example of breakdown in communication among couples was when they reported that some men did not want to discuss ANC attendance with pregnant women because they pregnant women nag a lot.

Communicating with men has been reported to pose challenges for programmes which historically have focused on serving the women (Young and kol, 1999).They also noted that it is not easy to design messages and materials that men find persuasive and that also promotes gender equality and women empowerment.

Some men feel it is a duty to facilitate their wives in terms of transport and if they do not have means of transport they see no point in escorting them while both are walking. Yet in many situations in Africa where the man is economically in position to provide the basic necessities of life he needs to have more than one wife, which also negatively affects willingness and ability to escort the wife for care. Multiple partner relationships promotes different interests for the man and his partners and will hamper possibilities for transparent decision making on maternal health

service issues in addition to involvement in maternal health services of all wives when needed. Radcliffe (2001) noted that men often are often involved in multiple sexual relationships that present a considerable challenge to fertility awareness and reproductive health programmes.

According to Thaddeus and Maine (1994) men can positively affect the prevention of maternal and child mortality by being able to recognize an obstetric emergency, take a decision to seek care and being able to transport the pregnant women to obtain health services. Men accompanying women for ANC present an opportunity to the health workers to health educate them and empowering men to be able to recognize an obstetric emergency early in order to make an appropriate decisions and actions that may influence the outcome of the pregnancy.

Sexual and reproductive health issues involve an emotional journey and both men and women need the emotional support and relevant services. Men rarely offer meaningful companionship during critical moments such as during antenatal care, PMTCT, labor, childbirth, family planning and treatment of STIs. Consequences of this include missed opportunities to access services for themselves or failure to appreciate the related women's needs and care.

The urgency of encouraging boys and men to take responsibility for their own SRHR and their partner's is gaining momentum. However, Uganda has not developed large- scale programs that reach out to boys and men. There have been attempts to engage men in ANC, birth planning and PMTCT through encouraging men to accompany their spouses and be tested for HIV (Uganda national strategy for male involvement, 2011). This can also be compared with what was reported by (UDHS, 2006) were 41% of the women delivered in the health facilities are accompanied by their husbands or partners. In the Eastern region where Iganga district is located and the central region it was 58% and 55% respectively of the women accompanied by their husbands or partners to deliver in the health facilities and this is slightly above the national figure (UDHS, 2006).

The Uganda SHR guidelines (2006), recommend that a mother should attend postpartum care during puerperium, only 23% of the mothers in Uganda receive postnatal care within the first two days and overall, 74% of the women who deliver in Uganda receive no postpartum care at all(UDHS, 2OO6). If men are well sensitized about postnatal care services and their concerns addressed, the number of mothers seeking postnatal care is likely to increase. Also in Uganda,

despite of health facilities being in walk able distances in many districts women continue to report late for ANC and deliver outside the health facility where there is qualified health worker (Kasolo and Ampaire, 2000).

Previous studies in Uganda have shown that most women attend ANC only once instead of the recommended minimum of four times, and never return for delivery. This has been attributed to a number of factors, the notable one among many is husbands deciding when and where a woman is to get ANC and delivery. This fact of male involvement's utilization of ANC and delivery in Uganda is supported by the finding of the done by Nyane (2007) in Tororo in which she observed that some pregnant women when asked to come with their partners during the next ANC visit dropped out and this seems to agree with the study by Kasolo and Ampaire (2000) in which they argued that poor knowledge of what is done at the health facility coupled with poor communication among the spouses and the status of women in the community greatly affect the utilization of ANC services in Uganda

CHAPTER THREE

3.0 METHODOLOGY

3.1: Research design:

The study design was descriptive cross sectional study.

3.2 Study Area

The study was conducted in Iganga municipal council which is found in Iganga district in Eastern Uganda on the Jinja –Tororo highway. It has an estimated population of 45000.Most of the people are illiterates or semi illiterate and this may affect their knowledge and attitude towards male involvement. Most of the men in this area have multiple wives and multiple sexual partners. The income in this area is low since most people are peasants depending on subsistence farming and small businesses to earn a living. In Iganga municipal council there is a hospital, two health centre IIIs and three health centre IIs.

3.3 Study population.

All men who are married and stay in Iganga municipal constituted the study population.

3.4 Sampling method

Simple random sampling method was employed in selecting the participants.

3.5 Sample size.

The sample size was obtained using the Fischer's formula which was stated in 1965 and its

$$n = Z^2pq/d^2$$

where n=sample size.

P=constant

Z=At 95% its 1.96

d=margin of error.

So the estimated male involvement in the municipal council is 8%.

So my p=0.08 and q= 1-p-0.05

q=1-0.08-0.05=0.87.N=1.96^2*0.87*0.08/0.0025=115

Therefore my sample size will be 115 participants.

3.6 Data collection and analysis.

A study questionnaire was used as the data collection tools and both quantitative and qualitative data was collected.

Descriptive data analysis was used; it was analyzed using the SPSS and Excel into tables and percentages and data was discussed in relation to the literature review.

3.7: Inclusion and exclusion criteria

3.7.1: Inclusion criteria

All married men who stay or work in Iganga municipal council were included in the study.

3.7.2: Exclusion criteria

Those who failed to consent, the sick and those who do not work or stay in Iganga municipal council were excluded from the study.

3.8 Ethical considerations

Letter of introduction was obtained from Dean Faculty of medicine and dentistry

Every participant signed a consent form which was translated in the local language.

Confidentiality of every information that was provided was ensured.

3.9: Quality control

- The questionnaires were pretested to ensure that the responses were in line with the objective.
- Questionnaires were edited daily before being entered.
- Randomization was carried out to avoid bias

3.10: Study limitations

- High level of illiteracy.
- Time to hand in the research report was short.
- Rainy season.

3.11: Delimitations.

- Simple and easy language was employed.
- Research assistants were used.
- Umbrellas were used by the researcher and the assistants.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION

4.0 Introduction

The findings of 115 male participants are presented in tabular form, pie charts and bar graphs after being analyzed using SPSS format and Excel. The findings are sectioned according to objective; socio-demographic, economic factors, knowledge and then support offered to spouses the by the men.

Table 1: Age of respondents

Age	Frequency	Percentage	Cumulative Percentage
15-20	5	4.3	4.3
21-30	53	46.1	50.4
31-50	53	46.1	96.5
>50	4	3.5	100.0
Total	115	100.0	

Most of the respondents (46.1%) were between the age of 21-30 and 31-50 years. Those below 20years and above 50 years were 4.3% and 3.5% respectively.

Table 2: Tribe of the respondents

Tribe	Frequency	Percentage
Musoga	89	77.4
Muganda	6	5.2
Samia	5	4.3
Itesot	5	4.3
Others	10	8.7
Total	115	100.0

The tribe which participated mostly were Basoga (77.4%) and the others which were Baganda (5.2%), Samia (4.3%), Itesots (4.3%) and others which included the Karimajong, Nyarwanda, Gishu and Bagwere (8.7%).

Table 3: Religion of the respondents

Religion	Frequency	Percentage	Cumulative Percentage
Moslems	35	30.4	30.4
Catholics	24	20.9	51.3
Protestants	53	46.1	97.4
Pentecostals	3	2.6	100.0
Total	115	100.0	

Most of the respondents (46.1%) were Protestants and these were followed by Muslims (30.4%), then Catholics (20.9%) and then the Pentecostals who made 2.6%.

TABLE 4:Education level of the men

Education level	Frequency	Percentage	Cumulative Percentage
None	6	5.2	5.2
Primary	12	10.4	15.7
Secondary	30	26.1	41.7
Institution	67	58.3	100.0
Total	115	100.0	

Most of the respondents (58.3%) had attained institution education and they were followed by 26.1% with secondary education, 10.4% primary level and those without any formal education were 5.2%.

Table 5: Marital status of the men.

Marital status	Frequency	Percentage	Cumulative Percentage
Married	87	75.7	75.7
Not married	5	4.3	80.0
Divorced	18	15.7	95.7
Widower	5	4.3	100.0
Total	115	100.0	

The married were 75.7% these were followed by the divorced (15.7%) and the widower and the not married were 4.3%.

Table 6: Number of years in marriage.

Years	Frequency	Percentage	Cumulative Percentage
1	14	12.2	12.2
2-5	36	31.3	43.5
6-10	35	30.4	73.9
>10	30	26.1	100.0
Total	115	100.0	

A high percentage of the respondents (31.3%) had been in marriage for 2-5years which was closely followed by those who had stayed for 6-10 years in marriage, 26.1%had been in marriage for over 10 years and only 12.2% have been married for 1 year

Table 7: Number of children of respondents.

children	Frequency	Percentage	Cumulative Percentage
1	33	28.7	28.7
2	20	17.4	46.1
3-5	36	31.3	77.4
>5	26	22.6	100.0
Total	115	100.0	

The majority of the respondents (31.3%) had 3-5 children while 28.7% had one child. This was followed by 22.6% with over five children and then 17.4 who had two children.

Table 8:Number of wives

No. of wives	Frequency	Percentage
1	89	77.4
2	15	13.0
More than 2	11	9.6
Total	115	100.0

Most of the respondents (77.4%) had one wife and these were followed by those with two wives (13.0%). 9.6% had more than two wives.

Table 9: Level of education of the wife

Wife education	Frequency	Percentage	Cumulative Percentage
None	6	5.2	5.2
Primary	14	12.2	17.4
Secondary	33	28.7	46.1
Institution	62	53.9	100.0
Total	115	100.0	

Most (53.9%) of the wives of the respondents had attained institutional education, followed by 28.7% whose wives had attained secondary education. Those with primary education were 12.2% and only 5.2% of the respondents 'wives did not have formal education.

Table 10: Shows occupation of the wives.

Occupation of wife	Frequency	Percentage
Peasant	78	67.8
Salary earner	11	9.6
Business woman	13	11.3
Others	8	7.0
House wife	5	4.3
Total	115	100.0

67.8% of the wives of the respondents were doing peasantry work, 11.3%were business women, 9.6% were salary earners,4.3% are house wives and 7.0%are doing others.

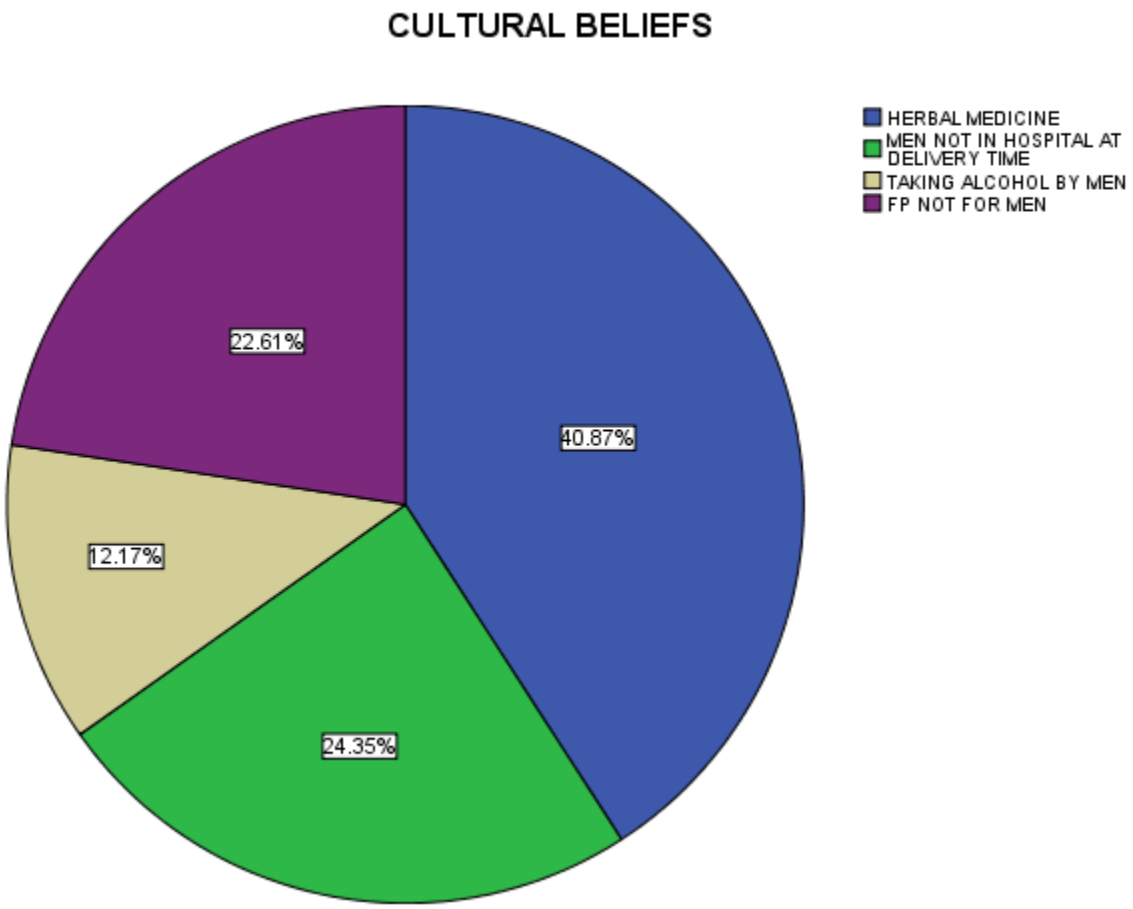

Figure 2:pie chart for cultural beliefs

40.87% believed herbal medicine can lead to low male involvement, 24.35% said that the men are not supposed to be in hospital at the time of delivery, 22.61% agreed that the belief that family planning is no for men can lead to low male involvement and 12.17% agreed that taking alcohol by the men can lead to low male involvement.

Table 11:Traditional beliefs leading to low male involvement

Traditional beliefs	Frequency	percentage
TBAs are very good	23	20.0
TM good during pregnancy	33	28.7
TM for sitting in helps women to deliver well	39	33.9
My mother can deliver my wife	20	17.4
Total	115	100.0

All the respondents believed that t traditional beliefs can lead to low male involvement in MCH as 33.9% said traditional medicine for the sitting in helps the pregnant women deliver well. Another 28.7% accepted that traditional medicine is good during pregnancy. 20.0% still believe that Traditional birth attendants in the community are good and another 17.4% also said that their mothers have been delivering many women in the community so they can also deliver their wives

Table 12: Shows occupation of respondents

Occupation of men	Frequency	Percentage
Peasant	15	13.0
Cival servant	32	27.8
Business man	46	40.0
Others	22	19.1
Total	115	100.0

40% of the respondents were business men, 27.8% civil servants,13.0% are peasants and 19.1% are doing other job like carpentry

Table 13: Monthly income of the respondents

Income of men	Frequency	Percentage
50000/=-100000/=	37	32.2
110000/=-200000/=	19	16.5
210000/=-400000/-	23	20.0
>400000/=	36	31.3
Total	115	100.0

32.2% of the respondents have a monthly income of 50000/=-1000000/= and 31.3% of the respondent have a monthly income of more than 400000/=shillings.20% earn between 210000/= and 400000/= while 16.5% earn between 110000/= and 200000/=.

Table 14: Residence of respondents

Residence	Frequency	Percentage
Personal	58	50.4
Renting	57	49.6
Total	115	100.0

50.4% reside in there own houses which they built and an almost equal number of respondents (49.6%) are renting were they stay

Table 15: State of house of the respondents

House	Frequency	Percentage
Permanent	70	60.9
Temporary	45	39.1
Total	115	100.0

60.9% of the respondents reside in permanent houses while 39.1% reside in temporary houses.

Table 16: Source of water of the respondents

Water source	Frequency	Percentage
Tape water	47	40.9
Bore hole	54	47.0
Well	5	4.3
Spring	9	7.8
Total	115	100.0

47.0% of the respondents use bore hole water, 40.9% use tap water, 7.8% spring water and 4.3% use well waters.

Table 17: Months mother takes to deliver

Months of delivery	Frequency	Percentage
8	3	2.6
9	105	91.3
7	2	1.7
0	5	4.3
Total	115	100.0

91.3% of the respondents knew that women deliver at 9months and 8.6% said 8, 7 and 10 months.

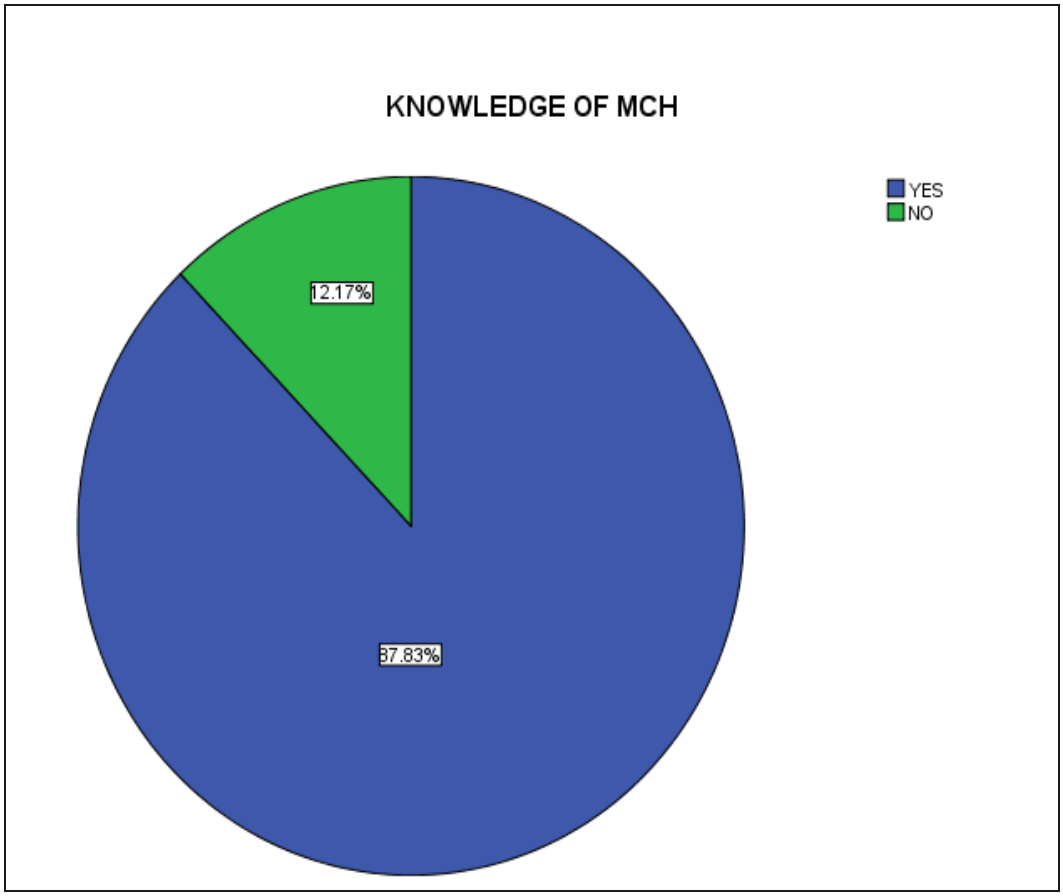

Figure 3:knowledge about mch services

87.83%of the respondents accepted that they had knowledge of MCHservices provided while the 12.17% did notn have knowledge of MCH

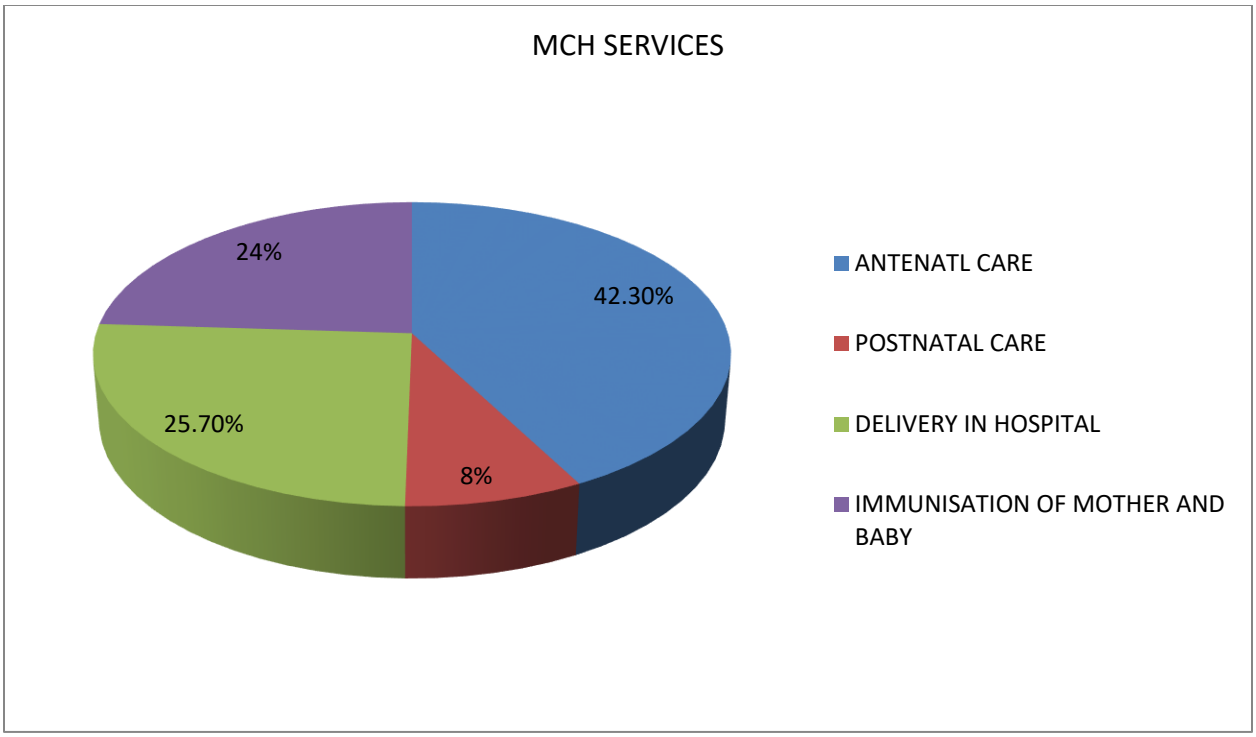

Figure 4:Known mch services to the respondents

42.30% of the respondents have knowledge about Antenatal care ,25.7% know about delivery in hospital, 24% have heard about immunisation of the mother and baby while only 8% know about postnatal care.

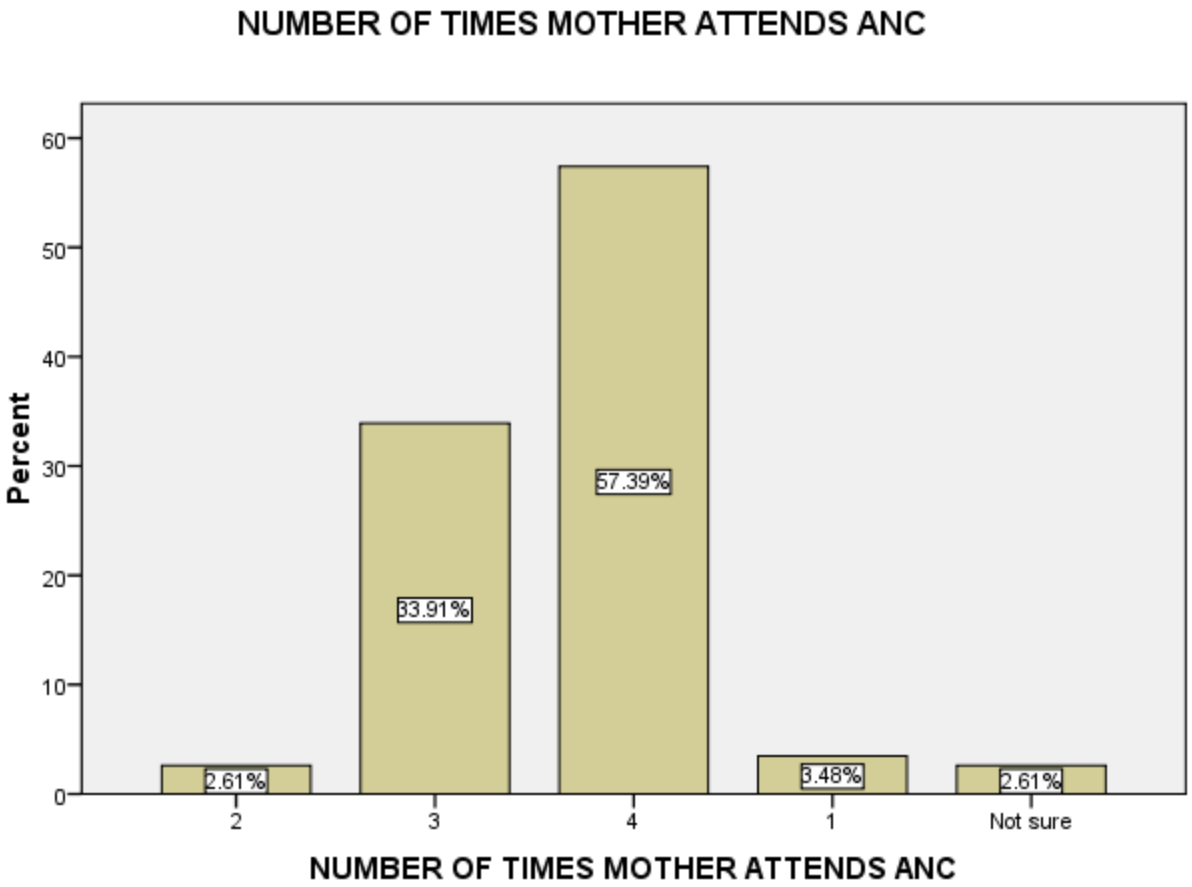

Figure 5: Bar chart for number of times women attend ANC.

57.39% of the respondents new the right number of ANC attendances a mother is supposed to go to hospital when pregnant, 42.6% gave wrong answers but some 2.61%were not sure

Table 18: Hospitals providing MCH in Iganga municipality except.

Hospitals	Frequency	Percentage
Iganga Hospital	23	20.0
Iganga Town Council H/c	5	4.3
Iganga Islamic Hospital	17	14.8
Iganga Prisons	57	49.6
Not sure	13	11.3
Total	115	100.0

49.6% knew the health facility which does not provide MCH services in Iganga Mnicipality, 39.1% did not know where the services are provided and 11.3% were not sure of the right answer

Table 19: Number of times a child is immunized

Immunization	Frequency	Percentage
2	3	2.6
3	15	13.0
4	27	23.5
5	62	53.9
No answer	8	7.0
Total	115	100.0

53.9% of the respondents knew that a child is supposed to immunized at least five times, 39.1% did not know the right answer and 7% did not have an answer.

Table 20: Shows number of respondents who escorted wives

Wife escorted	Frequency	percentage
YES	96	83.5
NO	19	16.5
TOTAL	115	100

83.5% of the respondents had ever escorted there wives for MCH services while 16.5% had never escorted there wives.

Table 21: Number of times respondents escorted wives

Number of times	Frequency	percentage
Once	23	20
Twice	22	19.1
Thrice	16	13.9
Four times	27	23.5
More than four	27	23.5
TOTAL	115	100

47% of the respondents escorted there wives four times and more,13.9% did it thrice, 19.1%escorted twice and 20% only escorted there wives for MCH services once.

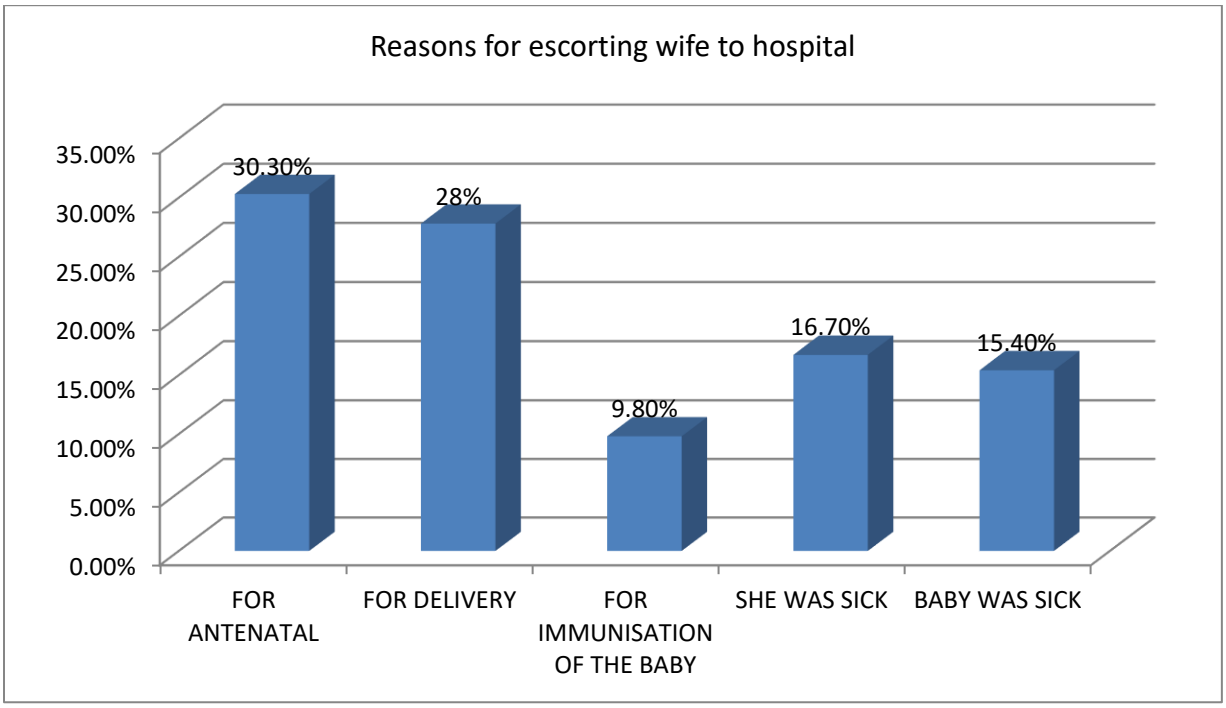

Figure 6: Reasons for escorting the women to Hospital

Most of the respondents (30.3%) escorted their spouses for ANC,28% escorted for delivery, 16.7% escorted her when she was sick,15.4% escorted when baby was sick and only 9.8% escorted their spouses to take child for immunization.

Table 22:Help provided to wife during MCH services

Help to wife	Frequency	Percentage
YES	101	87.8
NO	14	12.2
Total	115	100.0

Most of the respondents (87.8%) have provided support to their wives during pregnancy and postnatal care while 12.2% have not provided support to their spouses.

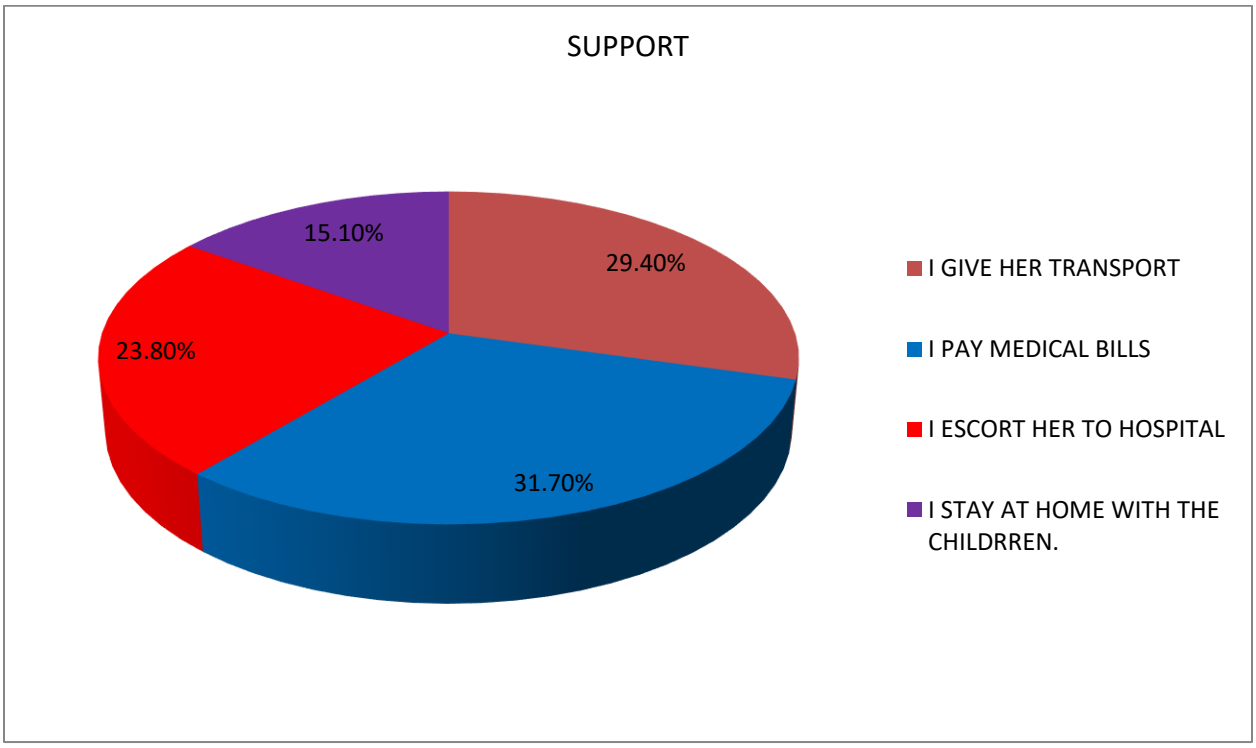

FIGURE 7: Pie chart for support provided to wives during MCH.

Most men pay medical bills (31.7%) for their wives, 29.4% provided transport to the hospital, while 23.80% do escort their wives to the hospital and 15.1% do stay home with the children

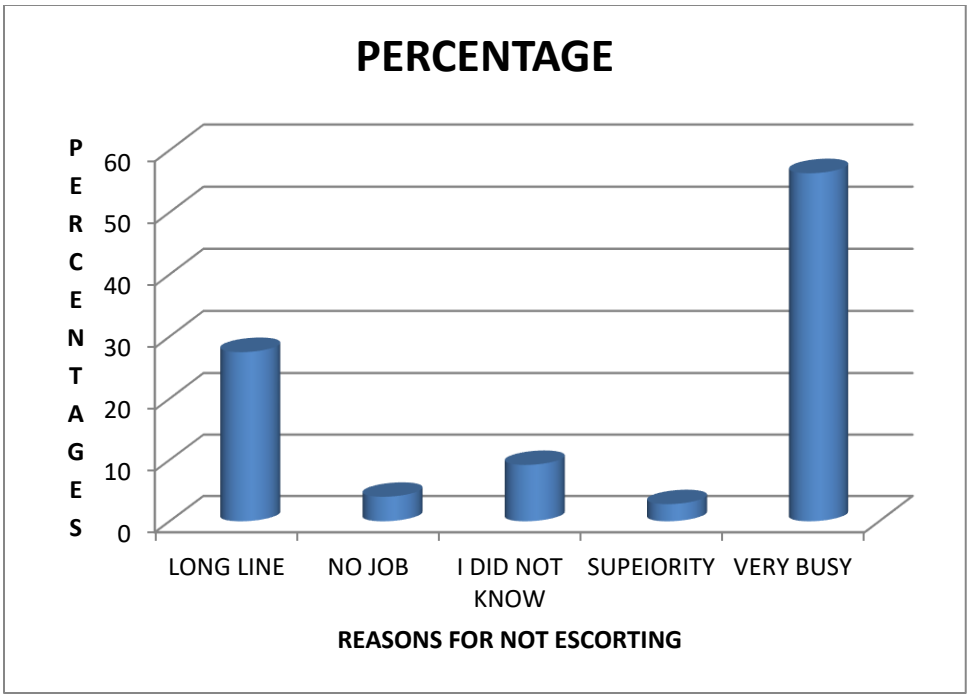

Figure 8: Reasons men give for not escorting their spouses

56.3% of the respondents said that they are always busy, 27.5% said it was because there was a long line of mothers in the hospital that they fear waiting for long hours,9.2%they did not know that they are supposed to escort there spouses to the hospital for MCH services,4.2% did not have jobs so no money for the mother and himself to go to hospital and 2.8% said that they are too powerful to be in hospital with their spouses.

CHAPTER FIVE
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

In this chapter the researcher is going to discuss his findings, make conclusions and recommendations about the study.

The objectives of the study were, economic and socio-demographic factors leading to low male involvement in maternal child health services and whether lack of knowledge about MCH services could lead to low male involvement

5.1.0 DISCUSSION

5.1.1 Socio- demographic factors

The age groups which participated in the study were 21-30years and 31-50years with 46.1% each and the other were 4.3% and 3.5%.Most men in these two dominant age groups feel strong and so rarely seek medical services or rarely go to the hospitals for treatment and this may affect male involvement in MCHservices since they may think that there spouses are also strong.

Table 2 was about the tribes in the study and the majority of the respondents were Basoga with 77.4%, 5.2% Baganda,4.3% Samia and Itesots and 8.7% for others which included Nyarwanda, Bagishu and Karimajong. The Basoga are majority because the study was carried out in Busoga region were they are the dominant group. These are too many tribes with different background and this may lead to low male involvement. This agrees with Uganda National Strategy for male involvement (2011-2016) which said that involving men in SRHR programs is particularly challenging for Uganda, which has many ethnic groups with diverse cultures, customs and taboos that define male gender. These culturally defined gender roles may hinder men's participation in MCH services.

Table 3 was about religion of the respondents and Muslims were 30.4% while the Christians added were 69.6%.This could also lead to low male involvement since some religions do not

come out openly to talk about Sexual Reproductive Health Services. For example the Catholics are not in support of Family Planning Programs and they do not talk about them and this will lead to unwanted pregnancy and the husband will leave it to wife to the solve the issue and hence low male involvement in MCH services.

Table 4 is about educational level of the respondents (men) and it showed that 58.3% had attained institution education while the 41.7%are one who ended in primary, secondary and the none at all. At the institutional level, understanding the concept of male involvement is easier as compared to someone who ended in primary or secondary or the one who didn't go to school at all. But also having a higher level of education improves communication among the couples and family at large and this will facilitate male involvement in MCH services. It will improve your information seeking behavior, you will understand your gender roles and you will pick interest in the reproductive health of your partner.

The findings in Table 5 indicate that 75.7% of the respondents were married, 4.3% not married, 15.7% divorced and 4.3% were widower. This is a positive sign for male involvement especially if the marriage is stable, because they are supposed to share all the MCH problems which affect the mother and also agrees with the study done Napal by Britta *et al*., (2004) which showed that men who shared problems with their partners were likely to make a joint decision on where the wife will deliver from.

Table 6 indicates that 87.8% of the respondents had been in marriage for more than 2 years and 12.2% for 1 year. This however leads to low male involvement as the years go by, things become normal because in the first years of marriage especially with the first baby the love is still too much and so the husband will be there with his wife. But as the years increase and with subsequent children the male involvement also dwindles.

Table 7 shows the number of children of the respondents and it indicates that majority have more than three children (53.9%) compared with 46.1% which have two children and below. This has a negative effect on male involvement as the bigger number of resources will be pulled to health,

education of then children. So the man will have no resource to inject in MCH services hence low male involvement.

The findings of table 8 show 77.4% of the having one wife while 22.6% having two or more wives. This 22.6% also accelerates low male involvement as the man may not pay attention to the maternal health needs of all the spouses and as a result low male involvement. This agrees with Ratcliffe (2001), who said that multiple partner relationships promotes different interests for the man and his partners and this will hamper possibilities for transparent decision making on maternal health services of all his wives when needed. And this presents a considerable challenge to fertility awareness and reproductive health programmes.

The findings in table 9.show 53.9% of the wives of the respondents having attained institutional educational level while a whole 46.1% had attained secondary education and below. Those with low education level (46.1%) will not demand there reproductive rights as they may not be aware. This is in line with (WHO, 2008) which said that a huge majority of African women are still unaware of the fundamental rights to health and they continue to suffer from the socioeconomic discrimination and unwanted pregnancies which are harmful to their health (Were, 2009) also emphasized that women tend to have less education and so fewer job opportunities, and this influences their maternal health seeking behavior and maternal health outcomes.

In table 10 it is seen that 67.8%of the wives of respondents were peasants only 9.6% were ably salary earners, 11.3% were business women, 4.3% house wives and the others were 7%. This has a big effect on women as they are not sure of daily income and they will have to depend on the husband to finance there seeking of MCH services. This agrees with the United Nations Expert Group on Women and Finance which estimated that 70% of the world's populations living on less than a dollar a day are women. This also makes husbands the primary decision makers and wife's economic dependence on her husband gives him greater influence on major house hold decisions, as was reported in Nepal by Britta *et al*., (2004).

In figure1all the respondents agreed that cultural beliefs have negative effect on male involvement with 40.87% saying that herbal medicine is good if used by pregnant women so

they do not see the importance of the woman going to hospital for MCH services if the herbal medicine is available. 24.35% said the male are a superior group to be in the hospital at the time of delivery or during ANC, 22.61% believe family planning is not for the men but women only and this agrees with (EngenderHealth, 2008) which said that men do not seek health information and services due to traditional notions of masculinity, where asking for help from a nurse or doctor is viewed as a sign of weakness. Many men it is their right to refuse contraception, to allow their partners or even discuss family planning. 12.17% said that alcohol taking can deter the men from getting involved in maternal child health services and this is because most of the time they will be drunk, leaving them with no money or time to facilitate the women for the needed care. Uganda National policy on male involvement (2011) noted that culturally men are decision maker in Uganda however; they have not empowered or supported women (decision and economically)to seek health care in a timely manner. This has often led to delay in seeking care as the woman waits for the spouse's consent and financial support thereby contributing to infant and maternal mortality

Table 11 is about traditional beliefs of the respondents and this indicated 20% believe traditional birth attendants lead to low male involvement as they are in the community and easy to reach, 28.7% and 33.9% believe in general traditional medicine for smearing, drinking and the one for sitting in when the woman is almost delivering are good and easy to get. So this makes the male reluctant encourage the wife to go for MCH services and by the time they realize its late and woman may die. 17.4% agree that some there mothers have delivered many people in there community and so they can deliver there wives too and this too can lead to low male involvement .and it also sometimes ends in death of the baby and mother. This also in line with (Kasolo and Ampaire, 2000) who said that traditional beliefs have also contributed to low utilization of ANC services, for example in some communities in Uganda there is a general belief that pregnant women have sexual intercourse with other men when they go for ANC and this has resulted in some men to refuse there wives to attend ANC.

5.1.2 Economic factors.

Table 12 indicates that the majority of the respondents occupation were business men 40%, 27.8% are civil servants, 19.1% do other jobs 13% are peasants. Of all the only group with a stable monthly income is the civil servant because there salary comes though small but the rest there income can change anytime depending on the prevailing circumstances. This can makes male involvement and attendance of MCH services tricky as attendance will depend on the day's income and if going to the hospital is not the priority she will not go.

Table 13 indicates the monthly of the respondents and it shows that 57.7% earn less than 400000/= per month and only 31.3% earn over 400000/=.This will lead to low male involvement since most of the families are living on less than a dollar a day and so they can not spend money for two people to go MCH services there is no food, school fees and other needs. The woman may go alone or she may not even go since it's not priority.

Table 14 is about residence of respondents and it shows that 50.4%are staying in personal houses while 49.6%are renting. This 49.6% also leads to low male involvement as the husband has to look for rent so he will not escort the wife to the hospital.

Table 15 is about the state of the house of the respondents and it indicates that 60.9% are in permanent houses and 39.1% are in temporary houses. 39.1% is a big percentage and it shows poor economical status and such a man may not be able to escort the wife to the hospital or even provide the basic requirements needed by the pregnant woman.

In table16 shows the majority of the respondents drawing water from the bore hole (47%), 40.9% tap, 7.8% from spring and 4.3% from the well. If people in town can draw water from a well or spring then it shows poor economic status because ideally people in town should use tap water which is extended to there home. But these cannot afford and so the probability he will escort the wife to hospital is also negligible neither will he be able to provide all the requirements needed for MCH services. And so this will lead to low male involvement.

5.1.3 Knowledge about maternal health services.

Figure 2 is about respondents who had knowledge of maternal child health services and it showed that 12.17% did not have any knowledge about MCH while 87.83% did have the knowledge about MCH. The 12.17% is a big number which cannot be under estimated because they cannot participate in what the do not know or in what they do not understand and this agrees with the Uganda National Strategy for male involvement, (2011) which stated that despite the global recognition at the level of international agreements, many countries have not developed large scale programs that reach out to men. As a result, many men are not aware of why they need to be involved in SRH, how they can be involved, and what services are available for them and there partners. So it is important to note that to increase male involvement in MCH services requires the providers to gain in depth knowledge and understanding of the men's health perspective, behavior and practices.

Figure3 is about MCH services which are known to the respondents and 42.3% said antenatal care, 25.7% delivery in hospital, 24% immunization of baby and mother while only 8% mentioned postnatal care. This means that when we tell men about MCH services all they understand is Antenatal care and this were most men are involved followed with delivery in hospital and very few know that PNC is also an MCH service.

Figure 4 indicates the knowledge of the respondents about the number of times a pregnant woman is supposed to attend ANC. Only 57.39% were right and they said it was 4, 39.98% gave a wrong answer and 2.61%were not sure. This just shows that the men have less knowledge and interest in MCH services. This explains what happened in Iganga district where a high number of women(106%) attended ANC first visit and only 47% of them finished the recommended four visitsHMIS,(2008/9) SO this will lead to low male involvement since the main decision maker and financer is not aware of the number of attendances a mother is supposed to make.

Table 17 was assessing knowledge of the men about the number of months a woman takes to deliver and 91.3% right answer of 9 months while the 8.7% did not know the right answer. This still shows you the knowledge gap among the men.

Table 18 was assessing the respondents knew where MCH services are not provided in Iganga Municipality and 49.6% gave the right answer,11.3%were not sure while 39.1% did not know the answers. So even here, its clear that the men lack the knowledge about health facilities were MCH services are provided and this leads to low male involvement since the decision maker and financer of the man has no knowledge.

Table 19 was assessing the men about knowledge of immunization of the baby from birth and 53.9% gave the right answer while 46.1% did not know the right answer. It is again showing that men lack information about MCH services, and this leads to male involvement as the man may not take serious the immunization of the baby and postnatal care of the mother.
In looking at this assessing knowledge you will find that men have knowledge gaps about MCH services and this agrees with Ntabona, (2002) who noted that it is widely recognized that men are often marginalized by the maternal health care provided with limited access to basic information and knowledge to help them make an informed decision and choice in order to promote their own health as well as that of their families. This also is line with what was agreed on, in the Beijing conference where it was emphasized that man's attitude, knowledge base and ways of reacting influences not only men's health but also women's reproductive health.(WHO,2007).

5.1.4 Involvement in MCH services of the respondents.

Table 20 was about escorting of the wife to hospital for MCH services and 83.5% said yes while 16.5% said no, so they had never escorted their wives to the hospital. This was good as the bigger percentage had escorted there wives for at least an MCH service. This is also above the national figure of 41% for delivery UDHS, (2006) and also above the figure for the Eastern region where Iganga municipality lies which is 58% UDHS, (2006). But we can also not under estimate the 16.5% who had never escorted there spouses to the hospital for MCH services, why they had not done, whether there are social, economic factors or lack of information and knowledge.

Table 21 is about number of times the respondent has escorted his wife for MCH services and 54.2% said they had escorted their spouses more than four times 15.6% thrice,16.7% twice while

13.5% only once. This indicates the male involvement is there but some men do it half hazardly and this leads to low male involvement.

Figure 5 is about the different reasons men gave for escorting there wives to the hospital and 30.3% said ANC,28% delivery,16.7% sickness of the wife,15.4% said the baby was sick and 9.8% was because of immunization of the baby and the mother. This figure agrees with figure 3 were most of the respondents also had more knowledge about ANC, delivery and postnatal care was the last. This means that if men are equipped with knowledge about MCH services and there need to participate, they will get on board. It is also noteworthy that postnatal care (immunization of mothers and baby is not known to many men as an MCH service so more information is needed in that area. This is in line UDHS, (2006) where only 23% of the mothers received postnatal care within the first two days and over, 74% of the mothers who deliver in hospitals in Uganda receive no postpartum care at all.

Table 22 shows whether the respondents support there wives during pregnancy and other MCH services.87.8%said yes they have been supporting the wives and 12.2% said no meaning they have not given any support to there wives.87.8% is good and it show that more men are getting involved in MCH services and so it should be encouraged. But still the 12.2% which do not give support to there wives which present a big challenge to the community as this will lead to failure to achieve 100% male involvement.

Figure 6 is on support given to wives by the respondents and 31.7% said they pay medical bills, 29.4% pay transport to the health facility, 23.3% escort them to the hospital and 15.1% keep at home with the children. By this you realize that what we call involvement does not only mean going to the hospital as other programs need to be attended to. The 23.3% who escort them to the hospital do the best thing as in the end they will also have gained more about themselves and the family at large and so it should be encouraged and this can improve delivery and ANC.

Figure 7 is about the reasons men give for not escorting their spouses to hospital and a majority of the respondents said it was because they were busy at their work places and this is in line with Bulut and molzan(1995) who noted that long working hours and difficult in taking time off

work to attend MCH services were also cited as reasons why men would be unable to participate in ANC services. 27.5% said the long line of mothers waiting for the make them not to participate in MCH. 9.2% said it was because they did not know that they where supposed to escort their spouses to the hospital.4.2% said they were jobless so they cannot afford to go with their wives as this is a waste of resources and 2.8% said the men are superior to be in hospital during MCH services. And if you critically look all these reasons you will see that they are economical, cultural, health facility and then lack of knowledge and information by the men.

5.2 CONCLUSIONS

5.2.1 Socio-demographic and cultural factors.

From the study it was noted there are so many tribes in Iganga Municipality and this presents diversity in culture and customs which need to be handled and understood differently.

Cultural beliefs and traditional beliefs have a big negative impact on male involvement as many people still believe in them.

Educational level of both the men and there wives is low for a big number of respondents and their spouses that is 41.7% for the respondents and 46.1% for their wives. This affects the uptake of MCH services since most of them may not understand the importance of the male getting involved in MCH.

5.2.2 Economical factors

Low income and unemployment in the family has a negative effect on male involvement in Iganga Municipality. This makes the men shy away from getting involved in maternal child health services.

5.2.3 Knowledge of the participants

There is a big knowledge gap about MCH services among the men in Iganga municipality and this leads to low male involvement. Low knowledge in ANC, delivery and postnatal care of the

men has a great negative impact on MCH services since they are the decision makers and financers of their wives who seek for the services.

Men have a big role to play in the provision and uptake of MCH services and so effort has to be made to ensure that they are brought on board as stake holders as they may be the solution to low male involvement.

5.2.4 Male involvement in maternal child health services in Iganga municipality

Looking at escorting the wives to hospital and supporting them in the different ways you realize that the average male involvement is at 85.7% and this far above the national figure of 41% and the one of the Eastern region where Iganga municipality lies which is 58%. This is very good and encouraging but there is a 13.3% which need to be brought on board so that we reach 100%.

Its also clear from this study that the only MCH services men commonly know are antenatal care and delivery in hospital and that is where they are participating most and so more effort have to be made to ensure that the men also understand and give equal importance to postnatal care, family planning and immunization of the babies.

From the study we conclude that men's involvement in MCH services is also through providing transport to the health facility, paying for medical bills and staying at home with the children. This calls for all of us to have broader view of male involvement not necessarily escorting the women to hospital and staying there with them.

The study also brings out the reasons men give for not escorting their wives to the hospital as being very busy at work, long line of mothers who need MCH services hence long waiting time, lack of knowledge of whether he was supposed to escort her to the hospital, being jobless so he could not afford to transport two people to the facility and then men feeling that they are superior and so they should not keep in hospital. And if critically analyzed these factors are economical, health facility related, cultural and traditional and then lack of knowledge and information.

5.3 RECOMMENDATIONS

5.3.1 Socio-demographic and cultural factors.

Community mobilization and sensitization should be done in Iganga municipality and this should be done in different languages to cover the cultural diversity in the municipality. This sensitization should also address the bad cultural and traditional beliefs and encourage the males in the community to become partners of maternal child health services.

Health education about maternal child health services should be done in primary and secondary schools and this also will increase awareness and boy child or student will grow up while knowing that he has the responsibility of caring for his spouse during the time of pregnancy and other maternal child health services.

5.3.2 Economical factors.

We should encourage the families in Iganga Municipality to setup income generating projects so to increase on their house hold incomes such that both the man and his wife can be able to attend MCH services whenever needed.

5.3.3 Knowledge of the male in Iganga municipality.

Health education of the males of the importance of getting involved in maternal child health services by using posters, radio spots in different languages, going to schools and also during outreaches done by the health workers.

We should also get male mobilizers for mobilization and sensitization of there fellow men about MCH services such that they can help increase their knowledge and information. These will majorly emphasize the different MCH services provided, where, when and how many times they are provided and there importance's.

5.3.4 Level of involvement in MCH services.

Community MCH services should be started and this can be done by integrating MCH services into normal outreaches and the people will be worked at in the community especially near public places like churches, mosques, markets and this will increase male involvement since the service will be near the working places of the males.

The hospitals should be encouraged to design mechanisms which ensure that the waiting time is reduced and hence increase in utilization of maternal services.

Appendix I

INFORMED CONSENT

KAMPALA INTERNATIONAL UNIVERSITY-WESTERN CAMPUS

INFORMED CONSENT FORM

Study Title factors associated with low male involvement in maternal child health service in iganga municipal council.

Principal Investigator: MR. Balwanyi Charles(TEL:077233065)

INTRODUCTION

I am Balwanyi Charles, PRESUING A Bachelors course in Medicine and Surgery from Kampala international University Western Campus (KIU-WC). I am currently conducting research on the topic above. The assessment will be conducted by the researcher and other trained experts. Your participation will provide useful information which will help the decision makers to improve on health service delivery and as a result utilization maternal child health services will increase and hence maternal deaths will decrease.

Confidentiality: The information you provide will be private and will not be disclosed to anyone. The information obtained will only be used for research purposes only.

.

Signature of participant Date

_____ _____

Signature of Researcher obtaining consent. DATE

……. ……

QUESTIONNAIRE

TOPIC: Factors Associated with low male involvement in Maternal child Health service in Iganga Municipal council.

1.INSTRUCTION.

- Answer all questions
- Tick the answer of your choice
- Use the blank spaces provided to write where need be

Participants I.D Number……

SOCIO-Demographic Information.

1. Age of participant

A) 15-20 years ☐

B) 21-30 years. ☐

C) 31-50 years ☐

D above 50 years. ☐

2.What is your tribe?

A. Musoga ☐
B. Muganda ☐
C. Samia ☐
D. Itesot ☐
E. Others specify……

3. What is your religion?

A. Moslem. ☐

B. Catholic ☐

C. Protestant. ☐

D. Pentocostals. ☐

4 What is you education Level?

A) None ☐

B) primary level ☐

C) secondary level. ☐

D)Institution or university. ☐

5. What is you marital status? A. Married. ☐ B. Not married ☐ C. Divorced ☐

D. Widower ☐

6. How many years have you been married? A.1year ☐ B. 2-5 years ☐ C. 6-10yrs ☐

D. above 10yrs ☐

7. How many wives do you have? A. 1 ☐ B. 2 ☐ C. More than 2 ☐

8. How many children do you have? A. 1 ☐ B. 2 ☐ C. 3-5 ☐ D. above 5 ☐

9. What is the Education level of your wife? A. None ☐ B. Primary ☐ C. Secondary ☐

D. Institution ☐

10. What work does she do? A. Peasant ☐ B. Salary earner ☐ C. Business woman ☐

D. Others specify...…….

10. What cultural beliefs do you think prevent men getting involved in Maternal child health services?

A. Women should take herbal medicine. ☐

B. Men should not be in hospital at the time of delivery. ☐

C. Taking alcohol by men.

D. Family planning is not good for men.

11. Which of the following traditional beliefs do prevent men from maternal child health services?

A. Traditional Birth Attendants are very good. ☐

B. Traditional medicine are good during pregnancy. ☐

C. Sitting in the traditional medicine helps the mother to deliver very fast. ☐

D. My mother has always delivered the women, so can do it to mine. ☐

.**Economic factors**

12. What is your occupation?

A. Peasant. ☐

B. Civil servant. ☐

C. Business man. ☐

D others specify…….

13. What is your average monthly income?

A. 50000/=-100000/= ☐

B.110000/=-200000/=☐

C. 210000/=-400000/=☐

D. Above 400000/= ☐

14. Residence

A. Personal. ☐

B. Renting. ☐

15. State of your house.

A. Permanent ☐ B. Temporary. ☐

16 .How many dependants do you have?

A. 1 ☐ B. 2 ☐ C. above 2 ☐

17. What source of your water?

A. Tap water. ☐ B. Bore hole. ☐ C. Well. ☐ D. Spring. ☐

Knowledge about Maternal Child Health

18. Have you heard about maternal child health services? Yes/ No

19. Can you mention some of them?

A. Antenatal care. ☐ B. Postnatal care. ☐ C. Delivery in hospital. ☐

D. Immunization of mothers and the babies. ☐

20. How many times are the pregnant mothers supposed to attend Antenatal?

A. 2. ☐ B. 3 ☐ C. 4 ☐ D. 1 ☐

21. How many months do women take to deliver?

A. 8.moths. ☐ B. 9months. ☐ C. 10.months. ☐ D. 7months ☐

22.The following hospitals provide Antenatal care except.

A. Iganga hospital. ☐ B. Iganga Town council H/c ☐ C. Iganga Islamic Hospital ☐

D.Iganga prisons H/C. ☐

23. How many times is a child supposed to be immunized?

A.2 ☐ B. 3 ☐ C. 4 ☐ D. 5 ☐

24. Have you ever escorted your wife to the hospital? Yes /No. (Tick)

25. If YES, how many times have you escorted your wife to the hospital?

A) Once. ☐

B) Twice. ☐

C) Thrice. ☐

D) four times ☐

E) More than four ☐

26. Tick if you escorted her for any of the following or all.

A. For antenatal care. ☐

B. For delivery of the baby ☐

C. For immunization of the baby ☐

D. She was sick herself ☐

E . The baby was sick ☐

27. What reasons do men give for not escorting there spouses to the hospital when she is pregnant or during delivery? Choose and TICK from the list below the reason(s).

- Very busy at my work place. ☐
- I did not know whether I was supposed to escort her to the hospital. ☐
- There is a long line in the hospital so it would take a lot of time ☐
- I have no job so no money for hospitals. ☐
- We the men are too powerful to be in hospital. ☐

28. Is there any help that you give to your wife during pregnancy or delivery? Yes/NO.(Tick)

29. IF yes mention at least 5 ways of how you support your wife during pregnancy or delivery.

A. I give her transport to the hospital ☐

B. I pay the medical bills ☐

C. I escort her to the hospital. ☐

D. I stay at home with the children. ☐

Thank you very much for your time

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