

**FACTORS INFLUENCING MALE PARTICIPATION IN ANTENATAL CARE
ATTENDANCE IN MAKINDYE DIVISION-KAMPALA DISTRICT**

BY

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2011 – BSCPH – PT – 049

**AN UNDERGRADUATE RESEARCH REPORT SUBMITTED TO THE INSTITUTE
OF HEALTH POLICY AND MANAGEMENT IN PARTIAL FULFILLMENT OF
REQUIREMENTS FOR THE AWARD OF A BACHELORS DEGREE IN
PUBLIC HEALTH OF INTERNATIONAL
HEALTH SCIENCES UNIVERSITY**

DECEMBER, 2014

DECLARATION

I, Annet NAMAYANJA declare that this research report has never been presented to any Institution for any Academic Award, publication or even other use. The work is therefore original and where the work of others is quoted, references are given as required appropriately.

Thus I present it for the Award of Bachelors Degree in Public Health of International Health Sciences University.

Student

Annet NAMAYANJA

.....

Date:

.....

APPROVAL

This piece of work which is a result of a research study carried out by Annet NAMAYANJA under my supervision has been approved for submission and examination.

Signed

Mr. John Bosco ALEGE

Date

DEDICATION

This work is dedicated to my dear aunt and sponsor of this course Miss Rachael Mayanja for her continued support. I greatly appreciate your efforts and may the Almighty God richly bless you.

To all my family members and friends who were there for me during the course, I appreciate and thank you a lot. God bless you all.

ACKNOWLEDGEMENT

I wish to thank my supervisor Mr. John Bosco ALEGE for the support and guidance he gave me during the whole process of this work.

To the entire staff of the Institute of Health Policy and Management at International Health Sciences University, I wish to say thank you for the dedication in ensuring that the course comes to completion.

I would also like to extend my gratitude to the town clerk of Makindye Division and the In Charges of the health facilities for the support.

Lastly I would like to thank my research assistants and my respondents for their cooperation during the study period.

OPERATIONAL DEFINITIONS

Antenatal care is a planned program of medical management of pregnant women and their partners directed towards ensuring pregnancy and labor become a safe and satisfying experience (MoH, 2006)

Participation: is the actual accompanying of the females to the health facility for ANC by their partners.

Male: Male refers to a managed eighteen years and above, having a right to marry and to start a family (Constitution of Uganda 1995).

LIST OF ABBREVIATIONS AND ACRONYMS

ANC	:	Antenatal Care
HIV	:	Human Immune Virus
ICPD	:	International Conference on Population and Development
KCCA	:	Kampala Capital City Authority
MoH	:	Ministry of Health
PMTCT	:	Prevention of Mother to Child Transmission
UBOS	:	Uganda Bureau of Statistics
UDHS	:	Uganda Demographic Health Survey
UN	:	United Nations
UNFPA	:	United Nations Population Fund
WHO	:	World Health Organization

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ABSTRACT

Introduction

In Uganda male involvement in ANC is generally low averaging 3% in 2006, MoH. This remains a challenge to safe motherhood since about 210 million women become pregnant each year with 30 million developing complications which result in over a half a million maternal deaths. Antenatal care is defined as the care given to a pregnant woman to ensure early detection and treatment of pregnancy related complications as well as providing education and information about pregnancy, child birth and peuperium in order to improve her health and that of the baby. For this to be effective their spouses need to be brought on board so that they give them the necessary support.

Objective

The objective of the study was to determine the factors influencing male participation in attendance of Antenatal care in Makindye division, Kampala Capital City Authority

Methodology

This was a cross sectional study employing both quantitative and qualitative techniques. A total of 384 expectant mothers attending ANC at the health facilities in Makindye division were randomly selected to participate in the study and 10 Key Informants were interviewed. Data was collected using semi structured questionnaires and Key informant interview guides. The quantitive data was then analyzed a computer Statistical Package for Social Scientist (SPSS version 16) at univariate, bivariate and multivariate levels of analysis and presented in a meaningful form using tables of frequencies, percentages and charts. Qualitative data was analyzed using thematic analysis.

Results

The results of the study indicated that 98(26%) of the men in Makindye division accompanied their spouses to the health facility for ANC. Factors that were associated influenced male participation in ANC attendance included; couples living together (pv=0.000) those who had 1-2 (0.001) children and those who had attained a high level of education (pv=0.002), among the individual factors. Those who were in polygamous relationships (0.002) and those who worked in sales and services (0.000) were the socio-economic factors that influence male participation in ANC attendance. While those who travelled a distance of less than 5km (0.002) and those who were recognized as a couple at the health facility (0.005).

Conclusion

In conclusion, the study revealed low male participation in ANC attendance of and limited knowledge of the respondents about importance of ANC in Makindye division. The outstanding barriers to male participation in ANC included men failing to get time off their busy work schedules and long waiting time. Strategies for improving male participation should include, empowering men and women with knowledge about ANC, formation of fathers' clubs at ANC, incorporate services for men alongside ANC like safe male circumcision and having policies that allow men with expectant partners time off work so as they accompany their spouses for ANC so as to promote male participation in ANC attendance.

CHAPTER ONE: INTRODUCTION

1.0 Introduction

This chapter consists of the introduction, the study background, the statement of the problem, study objectives, the research questions, significance of the study and the conceptual framework

1.1 Background to the study

Antenatal care is the kind of health care given to a mother before birth of a child (WHO, 2005). ANC is an opportunity to promote the use of skilled attendance at birth and healthy behaviors such as breast feeding, early postnatal care, and planning for optimal pregnancy spacing. Many of these opportunities continue to be missed, even though over two-thirds of pregnant women receive at least one antenatal visit (WHO, 2012).

Internationally, male attendance of skilled ANC and delivery care along with their spouses remains a challenge to safe motherhood. About 210 million women become pregnant each year with 30 million (15%) developing complications, resulting into over half a million maternal deaths (De bernis *et al* 2008). Developing countries account for more than 99% of all maternal deaths; about a half occurring in sub-Saharan Africa, and a third in South Asia (WHO, 2007). There is sluggish progress towards achieving the fifth Millennium Development Goal (MDG) in developing countries (AbouZahr, 2003). Male involvement in maternal health care has been described as a process of social and behavioral change that is needed for men to play more responsible roles in maternal health care with the purpose of ensuring women's and children's wellbeing (UN, 2009). The husband (male partners) is often depicted as the primary decision

maker, and wife's economic dependence on her husband gives him greater influence on major household decisions and can thus have bearing on the attendance of antenatal care (Britta *et al*, 2006). For the reason that men play a big role in decision making in the family, some researchers suggest that male involvement is a very significant factor to consider in finding a solution to the three main factors responsible for many of the maternal death (*Ibid*). The global attention for involving men in women's reproductive health programs was triggered by the International Conference on Population and Development in Cairo in 1994 and the International Conference on Women in Beijing in the mid 1990s after stakeholders realized the influence of men on women's and their own health, including women's ability to protect themselves from infection with the human immunodeficiency virus (HIV) as well as building gender equality as seen from the ICPD-POA emphasis below;

"... special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, (ICPD Program for Action Chapter 4, paragraph C).

As early as 2001, the World Health Organization (WHO) established proven safe motherhood interventions that are required at household, community and facility levels to enable every pregnant woman to have a safe pregnancy and childbirth, and to provide couples with the best chance of having healthy infants Portela *et al*, (2003). The strategies include; providing skilled attendants to prevent, detect and manage the major obstetric complications, together with providing equipment, drugs and other supplies (WHO, 2007).

Thus this formed part of the gradual shift from a demographic to a more holistic and rights based approaches to Sexual and reproductive health. At present, in terms of global coverage, ANC is a success story, 71 percent of women worldwide receive any ANC; in industrialized

countries, more than 95 percent of pregnant women have access to ANC. In sub-Saharan Africa, 69 percent of pregnant women have at least one ANC visit (WHO, 2010).

Uganda carries on to have one of the highest maternal and child mortality worldwide, with an estimated Maternal Mortality Ratio (MMR) at 435/100,000 and child mortality at 137/1,000 live births (UDHS, 2011). The Ugandan government has prioritized reproductive health strategies which center on accelerated reduction in maternal mortality and severe morbidity related to pregnancy and childbirth.

Male involvement in maternal health care is a relatively new approach in Uganda. Traditionally, maternal health care services have focused on women, with very little male involvement. According to the most recent study by (Kimara, 2013) on male involvement in maternal reproductive health services, the level of male involvement in Kampala is 48.5% for ANC.

Active male involvement in Antenatal care is necessary to increase utilization of maternal health services by the pregnant women and mothers. The aim of study was to examine the factors associated with male involvement in antenatal care in Makindye Division, Kampala District.

1.2 Statement of the problem

Male attendance of skilled ANC is a fairly new field to research in Uganda. The available estimates depict a low attendance averaging 3% in 2006 MoH, (2006) but are based on health facility information systems that monitor male attendance in the PMTCT program.

In Kampala the level of male involvement in ANC is at 48.5% (458) (Kimara, 2013). In Makindye division only 40% (of the total number of women who attended ANC in 2013) were accompanied by their partners for ANC in the year 2013, (KCCA, 2013).

WHO, 2008 recommends that all expectant mothers should be accompanied by their spouses for ANC. Antenatal care includes good medical, emotional, and nutritional support during pregnancy, advice on safe delivery, and management of pregnancy-related complications.

Low male involvement in ANC attendance has resulted in women not being able to have the recommended four ANC visits (WHO, 2007) thus causing preventable reproductive health complications and thus maternal mortality. Lack of male involvement in pregnancy and antenatal care has been identified as one of the major bottlenecks to effective program implementation in other countries too (Horizons Program Report, 2002).

The study therefore was done to assess the factors influencing male participation in ANC attendance in Makindye division, Kampala Capital City Authority.

1.3 Objectives of the study

1.3.1 General objective

To assess the factors influencing male (18-45 years) participation in antenatal care attendance in Makindye division, Kampala District.

1.3.2 Specific objectives

- i) To determine the individual factors influencing male (18-45 years) participation in ANC attendance in Makindye division, Kampala District.
- ii) To determine the socio economic factors influencing male (18-45 years) participation in ANC attendance in Makindye Kampala District.
- iii) To establish the health system factors influencing male (18-45 years) participation in ANC attendance in antenatal care service in Makindye, Kampala District.

1.4 Research questions

- i. What are the individual factors influencing male (18-45 years) participation in ANC attendance in Makindye division, Kampala District?
- ii. What are the socio economic factors influencing male (18-45 years) participation in ANC attendance in Makindye Kampala District?
- iii. What health system factors influence male (18-45 years) participation in ANC attendance in antenatal care service in Makindye, Kampala District?

1.5 Significance of the study

The results from the study may be used in enabling women to support their spouses to attend ANC and therefore adequately be able to recognize complications related to pregnancy.

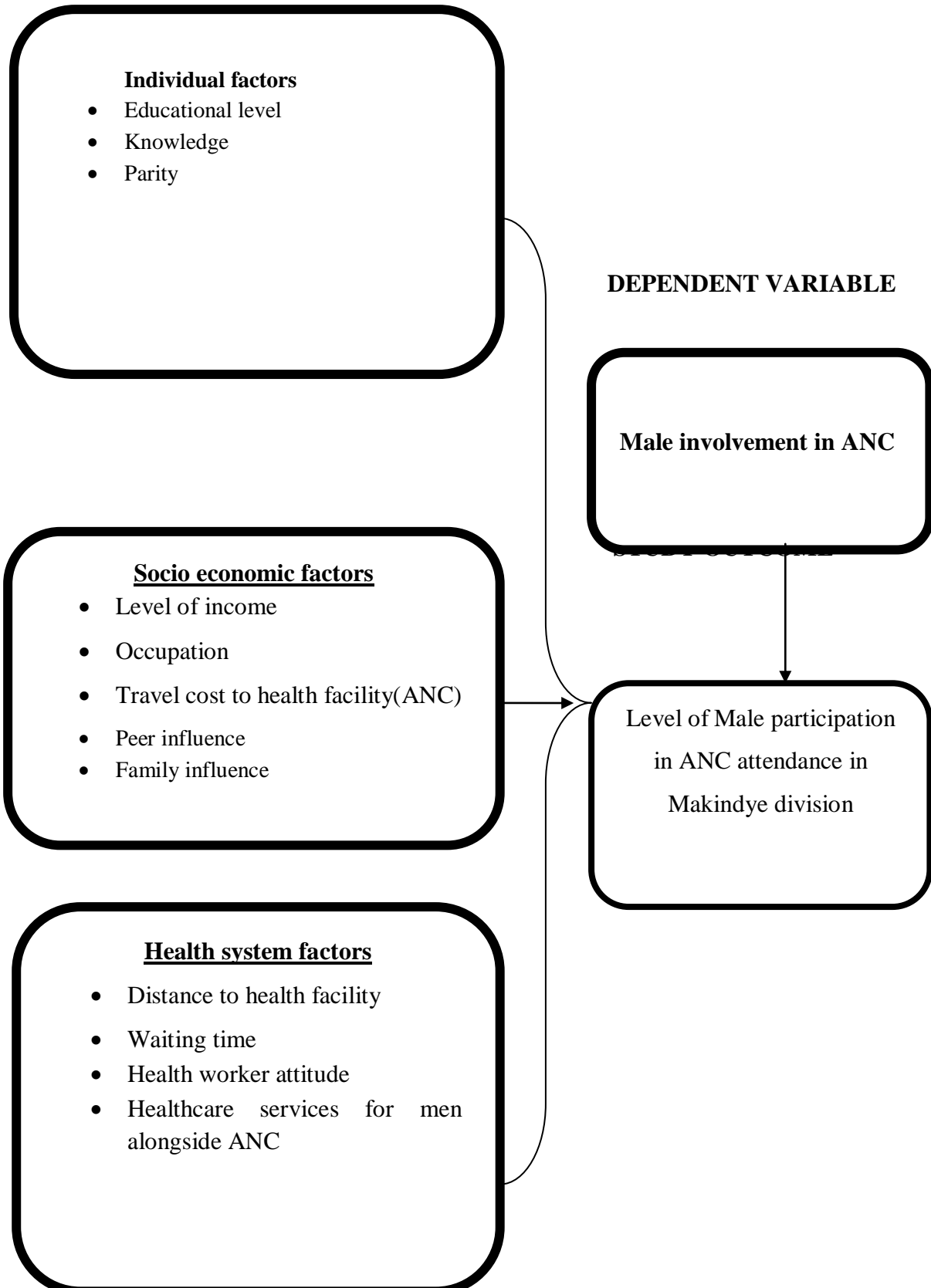
The results might be used to inform policy and to design new strategies that will encourage males to participate in ANC.

The study may be useful future researchers in terms of providing baseline data on male participation in antenatal care programs and act as a reference.

1.6 Conceptual framework

The conceptual framework illustrated below shows the variables that were studied.

INDEPENDENT VARIABLES



1.7 Narrative of the conceptual framework

Male participation in ANC was affected by a number of factors which include individual factors, socio-economic factors and health system factors.

The individual factors measured by beliefs, values, attitudes and level of knowledge influence male participation in attendance of ANC especially for the communities which believed that pregnancy was a woman's issue.

Socio- economic factors like occupation and level of income influence male participation in attendance of ANC since men were the bread winners of the family so they ought to be out there looking for money.

The health system factors which included distance from the health center, waiting time, health services that were available for men and the health workers attitudes may influence male participation in attendance of ANC.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents literature gathered from various sources on male participation in attendance of ANC. Among the issues discussed in this literature review are the individual factors, socio-economic factors and health system factors influencing male participation in ANC attendance.

2.1 Individual factors influencing male attendance of antenatal care

Reproductive health services that focus only upon women have limited impact and effectiveness. The Cairo (International Conference on Population and Development, ICPD) 1994 and Beijing, 1995 conferences have brought necessity of involving men as partner under sharp focus. “Male involvement” in reproductive health and family planning programs is not just promoting the use of male methods of contraception, but men’s supportive roles in their families, communities and workplaces to promote gender equity, girls’ education, women’s empowerment and sharing of child rearing and caring.

On the contrary other studies have found that facility interventions providing routine ANC have minimal beneficial effects to maternal health outcomes; creating a rationale for community-based interventions for pregnant women where educational and support programs have been triumphant in increasing and improving skilled delivery, breastfeeding practices and postnatal attendance Hounton *et al*, (2009).

This reported success may be mainly attributable to spousal involvement, and not necessarily the community as a whole. Even though it is widely recognized that there is limited research

on the role of male involvement during pregnancy Alio *et al*, (2009), there are promising links to beneficial effects. Indeed some few prospective studies and literature reviews have successfully demonstrated that prenatal male involvement is associated with beneficial health outcomes such as; higher first trimester ANC visits, abstinence from smoking and alcohol consumption Hounton *et al*, (2009), and reduction in low birth-weight infants Alio *et al*, (2009).

Evaluations of Prevention of Mother-to-Child Transmission of HIV (PMTCT) which is often implemented within the confines of safe motherhood have similarly shown male involvement to positively influence uptake of HIV testing and preventive interventions for vertical and sexual transmissions of HIV Hounton *et al*, (2009).

In particular it was argued that further progress in attaining reproductive health goals would depend on men changing their attitude and behavior towards reproductive health and gender issues. It also suggests the importance of responsible, respectful and non-coercive sexual behavior and shared reproductive health decision making (UNFPA, 2005).

Involvement of males in health care is generally poor as demonstrated by studies below from different scholars. This is evidenced by the fact that level of education among men on safe motherhood is likely to influence their participation in ANC. Demographic and Health Survey data (DHS) in Bangladesh between 1993 and 2004 found that education of the woman and her husband were important determinants of utilization of obstetric services Collin *et al* (2008).

Younger men, especially teenagers, are more likely to have unplanned pregnancies and lack information and resources to access ANC services as demonstrated in a Australia by Trinh, *et al* (2006). As regards marital status, single women with unplanned pregnancies, like most pregnant teenagers, may have a negative attitude towards the pregnancy of their spouses and, due to this, may be less aware of the signs of pregnancy and as a result might be more likely not to attend ANC with their wives than would older men Kogan, *et al.*(2008).

Inadequate knowledge about ANC and the benefits derived from it for the fathers has negatively influenced their involvement (Mullany, 2006). Sometimes men especially adolescents, may not be aware of the problems that results from not attending ANC and thus might not be supportive of their women to get involved in ANC services.

A study conducted in Uttar Pradesh-India found that men have limited knowledge of women's reproductive health matters Moore *et al*, (2007). Around 78 percent men in the study were unable to correctly identify the fertile period in the menstrual cycle and one-half could not correctly identify a symptom of serious pregnancy complications. The findings of this study are supported by another study in Maharashtra Brown *et al*, (2008), which shows that though majority of the men are aware of the need for antenatal, delivery, and postnatal care but fewer know details and fewer husbands accompany their wives for care; husbands are more likely to be present for care of problems than for routine care Brown *et at*, (2008).

However, an intervention study by Population Council indicated that men are interested in participating in antenatal care and can take more responsibility if they are provided adequate information and counseling about ANC Population Council India Study, (2006). The study clearly demonstrated that allowing men to participate in their wives' antenatal care by

providing information through individual and joint counseling increased couples' discussion and joint use of antenatal care.

A similar study done in India indicated that men having education above high school were found to accompany their partners compared to the ones whose education was up to primary school, Abhishek Singh, Faujdar Ram(2009). While a similar study in Kinshasa indicated that the level of education did not influence male participation in ANC attendance Ditekemena J *et al*, (2011)

A study done in Malawi indicated that women have experienced resistance from their partners because of fear that members in the community might interpret her partner's role in work that is culturally regarded as women's domain. Therefore cultural values and norms may prevent men from being involved in ANC. Chinkonde J *et al* (2006).

Several demographic studies have shown that men may want larger families than their wives (Anderson, 2007). In West Africa for example, men want four more children than women, though in Bangladesh, East Africa, Egypt, Morocco and Pakistan, men and women express similar desires in terms of family size, Ezeh, Seroussi, and Raggars, (2006). A study done by Simkhada *et al* (2008) revealed that parity negatively influences ANC attendance which means that the more children a woman had the lower the chances for her to attend ANC hence lower male participation. This may be attributed to the fact that as the women go through their first pregnancy they get support from their spouses but as they gain more experience this ceases to be the case.

Reproductive studies have always targeted females while males have largely been excluded from such programs that provide these services Edwards *et al*, (2004).

Most ANC programs are designed to be used by females. Men seem to be less concerned than women about ANC, perhaps because the former do not carry the burden of pregnancy and child birth directly.

So far as pregnancy care is concerned, a study conducted in Maharashtra found that majority of husbands in the State accompany their wives for the first check up to confirm pregnancy; but the women generally went alone or with the other female members of the family for subsequent visits Barua *et al*, (2002). It also found that husbands ignore wife's health care during pregnancy, except for the awareness for the need for antenatal registration and a nutritious diet.

The husband's role during the prenatal period was explained by gender-specific reasons – house hold chores were women's job, men only assist when the woman is pregnant and cannot manage to perform. Men were identified with masculine role of providing - financial support, similarly, in a study done in Guatemala it was found that the most universal form of male participation during pregnancy was financial support nutrition, psychological support and birth preparedness in terms of material support and transport arrangements (Horstman, 2009).

The identification of men with masculine roles affirm the notion that some men are socialized to be superior in terms of decision making and to be financial providers. As such it has proved to be difficult for them to participate in activities that are feminine including health issues concerning their wives (Horstman, 2009). At the same time, although some have

desired to support their partners, they have been curtailed by cultural definitions of maleness and roles of masculinity. As a result, they fear being disliked and ridiculed by other men in the community whom they imagine will call their manhood into question.

In addition, Olayemi *et al* (2009) that argued that men can participate in helping pregnant women stay health by making sure that the women get proper antenatal care which may entail providing transportation or funds to pay for her visits, accompany the wife during antenatal visits where the man can learn about the symptoms of pregnancy complications and how to respond to an obstetric emergency. Similar views are also shared by Roth and Mbizvo , (2001).

Olayemi et al (2009) found in their study that monogamous unions were associated with increased male participation in ANC; hence the type of marriage highly influences male participation in ANC. While a similar study done in northern Tanzania found that partners living together was associated with male participation in ANC Msuya *et al* (2008).

A study conducted in Kenya revealed that poor communication between husband and wife is an important barrier to the involvement of men in antenatal care (Omondi-Odhiamb, 2004). The success of male involvement in ANC depends on the agreement and cooperation of husband, while communication between spouses also improves the chance of effective ANC. Similarly, in a study done in western Kenya, Onyango *et al* (2010) observe that gender norms were one of the factors that inhibit male involvement in maternal health care. For instance, men are not expected culturally in Kenya to accompany their wives to the clinic. If they do, this was perceived by their peers as a demonstration of weakness.

Lack of knowledge about dangers of not seeking health care in pregnancy and delivery, including inability to make independent decisions were major barriers to seeking health care among men in Uganda (Matua, 2004).

Long working hours and difficult in taking time off work to attend services were also cited as reasons why many men would be unable to participate in ANC care services (Nantamu 2011). A similar study done in Gulu also indicated waiting time as a barrier to male participation in maternal health services, Tweheyo *et al*, (2009).

According to (UBOS 2006), it is indicated that low level of education is associated with reduced ANC by pregnant women. This may as well hinder the men from attending ANC with their partners.

2.2 Socio economic factors

For the men who feel that it is their duty to facilitate their wives transport to attend hospital sees no point in accompanying them if they do not have enough transport for the both of them. Therefore they prefer their wives go to the hospital alone so as to save on the transport costs, Ratcliffe (2001).

Multiple partner relationships promotes different interests for the man and his partners and this will hamper possibilities for transparent decision making on maternal health service issues in addition to involvement in maternal health services of all his wives when needed. Reporting his findings (Ratcliffe 2002) noted that men are often involved in multiple sexual relationships that present a considerable challenge to fertility awareness and reproductive health programs.

Income at household level has a bearing on antenatal attendance for both partners. This was established in Studies from Jamaica that found that, an increased probability of joint antenatal care attendance was associated with increased household expenditure Gertler *et al.* (2003).

Compared to men of low literacy level, educated men bear fewer children and achieve better child survival, because they avoid early marriages, teenage pregnancy, and high parity because they attend antenatal and postnatal more frequently. A study done in Kwale district, Kenya revealed that men with at least secondary education or above were more likely to attend for ANC Brown *et al.* (2008).

Household income levels and how resources are distributed may affect male participation in ANC. Msuya, Mbizvo *et al* (2008) in Tanzania found that having high monthly income is associated with male participation in ANC.

Alcohol consumption by the men has also been noted to plays an important role in keeping men away from involvement in maternal health care services as most of the time they may be drunk, leaving them with no money or time to facilitate the needed care.

2.3 Health system factors

Generally research shows that service related factors are more important than user related factors in affecting male involvement in maternal health care services. The most important ones pointed out include, long physical distance from the health unit, lack of transportation, inconvenient clinic hours, long waiting time at the clinic, poor technical and interpersonal skills. 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 2005) 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 may actively discourage men from participating in maternal health care services by the structure of services or by attitudes of health care workers.

In a study done by Dennis *et al.* (2005), some women stated that the reasons affecting their regular attendance at the antenatal clinic with their pregnant spouses were the long waiting hours, inconvenient service hours and that they were not treated well by the service providers probably because of not being the recipients of the service. The judgmental nature of some health workers towards adolescent spouses may negatively influence teenage male's efforts to attend antenatal services Zwellings *et al.*, (2004).

Physical accessibility of health services has been an important determinant of utilization of health services in developing countries. WHO reported that distance from MCH services, and the time and the cost involved in traveling to services are significantly associated not only with ANC use but also with the use of institutional delivery, postnatal and infant care services (WHO, 2007).

However, 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 informed choices and decisions 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 antenatal care consultations or during labor or delivery.

According to the (WHO 2007), a reasonable distance to the health facility should be about five to ten kilometers Dennill *et al.* (2002). (Smart 2000) states that the environment in which

services are provided for young fathers to be should be appealing to them, probably by avoiding the ‘clinical’ atmosphere often associated with hospitals or hospital-based care.

A study done in Kalabo district of Zambia Stekelenburg *et al*, (2004) on maternity services indicated that, distance is a significant factor affecting delay to decide to seek care from health facilities. It also influences the delay caused by the travel time from home to the clinic. The geographical features of Kalabo district, the uneven distribution of facilities and the absence of any roads or transport systems were also hindrance factors to maternity service utilization Stekelenburg *et al*. (2004).

In a similar study done in Cameroon it was revealed that some providers do not allow men to access ANC settings which on the other hand make these people believe that they are attended to hence stopping at the door Nkuoh *et al*, (2010).

Byamugisha *et al* (2010) in a similar study conducted in eastern Uganda revealed that harsh and critical language towards women from skilled health professionals was a barrier to male participation.

In her study (Nantamu, 2011) reported that significant barriers within the health care system itself are some of the issues cited by clients as impediments to father’s participation in ANC. Long working hours and difficult in taking time off work to attend services were also cited as reasons why many men would be unable to participate in ANC.

In Uganda, Maternal and Child Health (MCH) services implementers and providers largely ignored the role of men.

In Uganda, 41 percent of the women who deliver in the health facilities are accompanied by their husbands / partner (UDHS, 2006). The central region where KCCA hospitals are located having 58 percent and 55 percent of women accompanied by their husbands/partner to deliver which is slightly higher than the national average (UDHS, 2006).

Part of the reason for the low male involvement have come a 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 Muwa *et al*, (2008).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter contains the methods that were used to execute the study; it entails a description of the study design, the study population, sampling procedures, data collection methods and the tools.

3.1 Study Design

This study adopted a descriptive cross sectional study design. This design was chosen because it has the advantage of making it possible to study both the exposure and the outcome at the same time. Potential exposure (male involvement) and outcome (antenatal care services) was measured at the same point in time.

3.2 Study population

The target population was expectant mothers at the health facilities. This was chosen because it would justify why the mothers did not attend ANC with their partners.

3.3 Inclusion criteria

Expectant mother aged between 18-45 years seeking ANC services at the hospitals and health centres that consented to participate in the study.

3.4 Exclusion criteria

Expectant mother below 18 years and above 45 years or those in the age category for the study but do not consent to participate in the study.

3.5 Sample size calculation

The sample size was calculated using the formula by Kish Leslie (1964) as shown below;

$$n = \frac{Z^2 \times p(1-p)}{e^2}$$

Where;

Z = standard normal value corresponding to confidence interval (95%) = 1.96

p = proportion of attribute in the population under study (male involvement in ANC) = 50%

e = Accepted margin of error = 5%

$$\frac{1.96^2 \times 0.5(1 - 0.5)}{0.05^2}$$

n = 384 expectant women

3.6 Data Sources

The data sources included:-

Primary Sources: Primary sources provided first-hand testimony or direct evidence concerning a topic under investigation; in this study, these included the women seeking ANC services from any of the sampled health facilities and key informants who consisted of health care workers in the facilities.

Secondary sources: A secondary source of information is one that is already existent.

3.7 Sampling Techniques

Two sampling techniques were used in this study. These were systematic sampling and simple random sampling. Systematic sampling was used to sample the health centres in the division. The list of all health centres and hospitals was obtained from the division and the facilities to participate were selected using systematic sampling. A proportion of the mothers to be sampled was estimated according to the average number of ANC mothers seen per day at a given health facility.

At the health centre and hospital level simple random sampling was used to sample and interview the expectant mothers. In using this method, a list of names of the women registered as recipients of ANC services at the health centre was obtained from the respective records.

Each of the names was given specific numeric codes, which were then written on pieces of paper. These pieces were put in a box and shaken to mix them, followed by drawing one by one from the box and identifying the woman corresponding to the numeric code. This was done until the required number is reached.

3.8 Study variable

A variable is any factor that can take on different values and influences the outcome of the research. In this research, they include:-

Independent variables; Individual factors including level of education, knowledge of ANC, attitude towards ANC, beliefs, parity, peer influence, family influence and media, Socio economic factors that include occupation and level of income, health system factors that include the distance to the health facility, the waiting time, travel cost, attitude of health workers and services for male alongside ANC.

Dependent variable; Male participation in ANC attendance

3.9 Data collection techniques

Structured questionnaires: questionnaires allow the researcher to “explore and probe participants’ responses to gather more in-depth data about their experiences and feelings. They can examine attitudes, interests, feelings, concerns, and values...” (Gay & Airasian, 2002).

Many qualitative studies opt to combine observations and interviews as methods of data collection given that they can build on each other and prove quite complementary. In this fashion, participants typically reveal beliefs and attitudes toward the issue at hand. As in this study, formal, in-depth interviews were conducted with the women and men in the sampling frame.

Key Informants Interviews: Key informant interviews involve interviewing a selected group of individuals who are likely to provide needed information, ideas, and insights on a particular subject (Burns and groove, 2005). The key informant interviews were held with the in-charges of the health facility and other key medical personnel in the facilities. These key informants were chosen centres.

3.10. Data collection tools

Researcher administered questionnaires

Structured questionnaires were used in this study, these was given to the study participants who are able to answer and face to face interviews was conducted with those who cannot read and write. Semi structured questionnaires were used because they are inexpensive and useful where literacy rates are high, and participants are responsive. Both closed and open questions were asked.

Key informant Interview guide

The Key Informant Interview Guides were used to collect a broad range of perspectives on the state of male involvement in ANC. The semi-structured interviews were designed to collect information from the point of view of participants in their own words about the male involvement, interventions in place to increase involvement.

3.11 Quality Control

Training research assistants; research assistants that was hired to help with the data collection was trained on ethics in human research, the overall concept of the research and how to interpret the questions in the study tool to the respondents.

Pretesting; the questionnaires was tested in one of the health centres where women were not to take part in the study so as to ensure consistency and collects the information that is required to address the purpose of the study.

Translation; the questions in the study tools was translated to the local language the women was able to understand (Commonly Luganda) so as to ensure correct responses.

Triangulation; the quantitative data and the qualitative data were compared to ensure that the information given by the respondents does not differ from that of the key informants.

3.12 Data analysis plan;

The data was process and analysed by cleaning and organizing it, checking for accuracy, entering it into the computer, transforming it into the analysis package.

Quantitative data analysis: The data collected was analyzed using a computer Statistical Package for Social Scientist (SPSS version 16) at univariate, bivariate and multivariate levels of analysis. Data was also arranged in a meaningful form, into tables of frequencies, percentages and charts.

Pearson Chi squares were used to establish relationships between the independent and dependent variables.

Qualitative data analysis: Qualitative data was analyzed using thematic analysis. In this analysis emphasis was out on pinpointing, examining, and recording patterns (or "themes") within data. Themes are patterns across data sets that were important to the description of a phenomenon and associated to a specific research question. The themes were the categories for analysis. Thematic analysis was performed through the process of coding in six phases to create established, meaningful patterns.

Measurement of Outcome variable

Male involvement was measured by calculating the frequencies of male spouses who responded “yes” to questions regarding participation in ANC

3.13 Dissemination of Results

Upon acceptance of the research findings by the University (IHSU), copies of the same shall be disseminated to the division, each sampled health facility, the respondents in form sensitization and health education and later made available on line through academic portals.

3.14 Ethics Consideration

Confidentiality: the respondents were assured that the information they are sharing was kept confidential and will not be used in any other way apart from the purpose of the study.

Consent: a copy of the consent form was attached and given to the participants to sign. The objectives of the study were clearly explained to the participants. Those with concerns or questions were helped to understand.

Respect: All decisions of participation or non-participation were respected. Additionally, the mothers were handles with the utmost of respect during interviews.

Risks: In this case, the study was done in the participant's choice area of healthcare. The study therefore only aimed at finding out what possible association existed between various factors and male involvement with a view of recommending improvements. No risks was involved; nobody was publicly embarrassed

3.15 Limitations of the study

Not so many hardships were encountered during the study apart from the bad weather due to the rainy season that interfered with the data collection especially due to the fact that motorcycles are the convenient means of transport in the division.

CHAPTER FOUR

PRESENTATION AND INTERPRETATION OF RESULTS

4.0 Introduction

This chapter shows how the results were presented in form of tables, figures and charts and also how these are interpreted.

4.1 Individual factors influencing male participation in ANC attendance

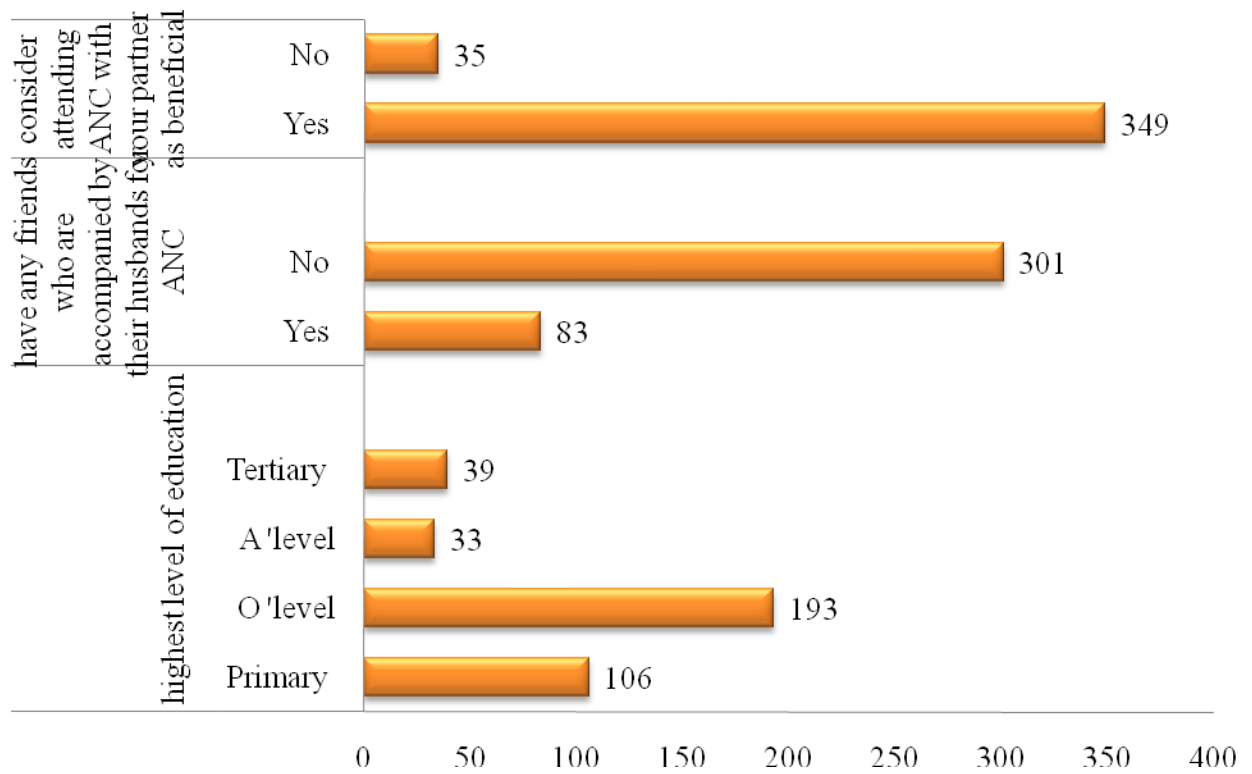
Based on the results in table 1 below, 235(61.2%) of the total (384) respondents were within the age group of 21 to 30 years. On the other hand, a bigger percentage of the respondents 183(47.7%) reported living together with their spouses (cohabiting) but not married. The majority of the respondents 109 (28.4%) were Catholics

Out of the total respondents, 191(49.7%) had 1-2 children. However, 112(29.4%) of the respondents did not have any child but were expecting their first child. Out of the total respondents 13(3.4%) reported they did not attend any formal education while a bigger percentage 193(52.0%) of the total respondents completed ordinary level (O 'level) of education.

Table 1: Individual factors

Factor	Frequency	Percentage
Age of respondents in complete year		
18-20 years	86	22.4
21-30 years	235	61.2
31-40 years	58	15.1
41-49 years	5	1.3
Total	384	100.0
Marital status		
Never married	54	14.1
Married	143	37.2
Living together	183	47.7
Divorced/separated	4	1.0
Total	384	100.0
Religion		
Protestant	68	17.7
Catholic	109	28.4
Pentecostal	56	14.6
Muslim	83	21.6
SDA	19	4.9
Born again	49	12.8
Total	384	100.0
Number of children		
1-2	191	49.7
3-4	69	18.0
5>	11	2.9
Don't have	113	29.4
Total	384	100.0
Have you ever attended school		
Yes	371	96.6
No	13	3.4
Total	384	100.0

Figure 1: Education level and whether respondents had any friends who attended ANC with their partners



Only 83(21.6%) of the total respondents had some friends who were accompanied by their husbands for ANC. Lastly, a significant percentage of the respondents 189(49.2%) did not receive encouragement from their family members that their spouses accompany them for ANC.

More than three quarters of the respondents 349 (90.9%) considered attending ANC with their partners as beneficial. Beneficial in a sense that they get the information concerning ANC as a couple and are therefore able to agree on certain issues like birth preparedness as a couple

4.2 Socio-economic factors influencing male participation in attendance of ANC

Responses sought on socio-economic factors as reflected in table 2 below show 71(18.5%) of the total respondents were in a polygamous marriage. In regard to occupation, 117(30.5%) of

the total respondents were in sales and services. Although the biggest proportion of the respondents 146(38.0%) were not doing anything.

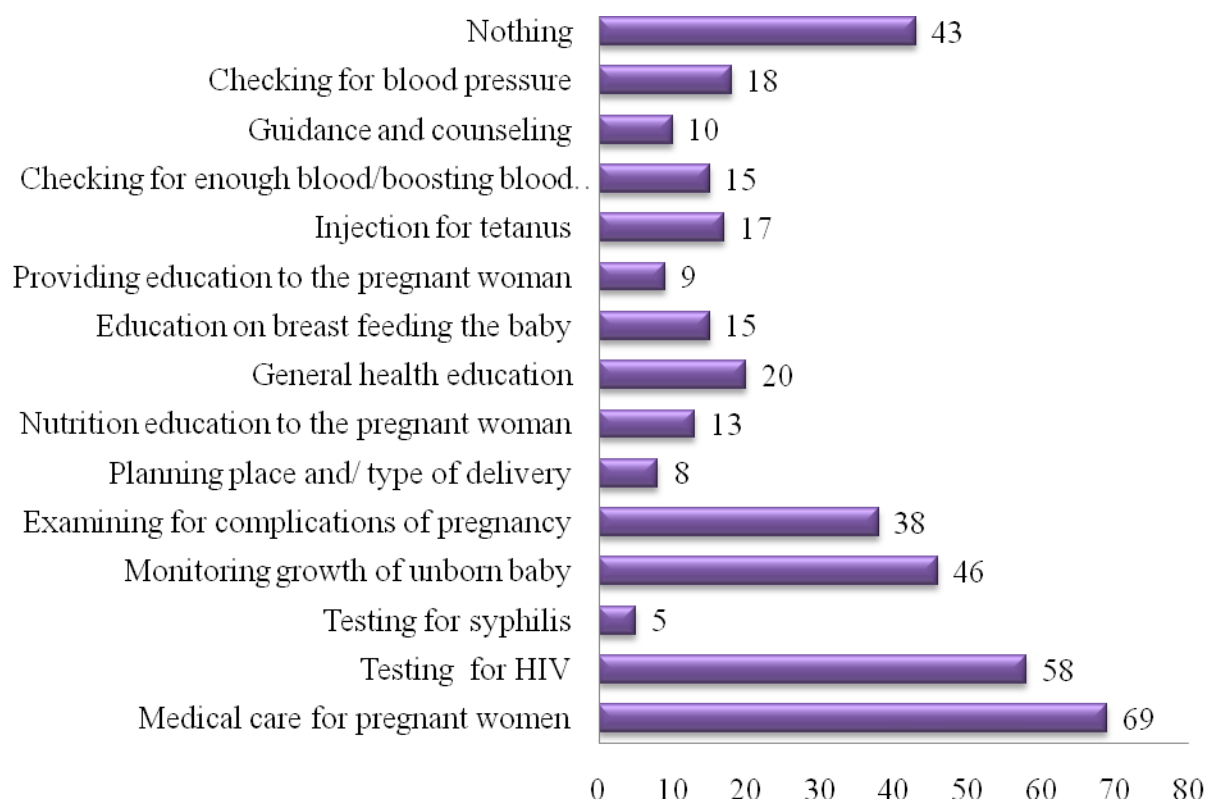
Out of the total respondents, 174(45.3%) used motorcycles as a means of transport to and from the health facility. Close to three quarters of the total respondents 265 (69.0%) reported they spent less than 5000/= on transport.

On the aspect of their average monthly income, 219(57.0%) of the total respondents did not earn more than 250,000/=.

Table 2: Social- Economical factors

	Frequency	Percentage
Type of marriage		
Monogamous	284	74.0
Polygamous	71	18.5
Don't know	29	7.6
Total	384	100.0
Occupation		
Unskilled manual	21	5.5
Skilled manual	45	11.7
Sales and services	117	30.5
Professional/Technical	36	9.4
Domestic	19	4.9
No	146	38.0
Total	384	100.0
Transport means used		
Walking	97	25.3
Bicycle	6	1.6
Motorcycle	174	45.3
Public means	103	26.8
Private means	4	1.0
Total	384	100.0
Amount spent to travel to health facility		
<5000/=	265	69.0
10,000-20,000/=	24	6.2
Nothing	95	24.7
Total	384	100.0
Average monthly income		
<250,000	219	57.0
250,000-500,000	31	8.1
500,000-750,000	5	1.3
None	129	33.6
Total	384	100.0

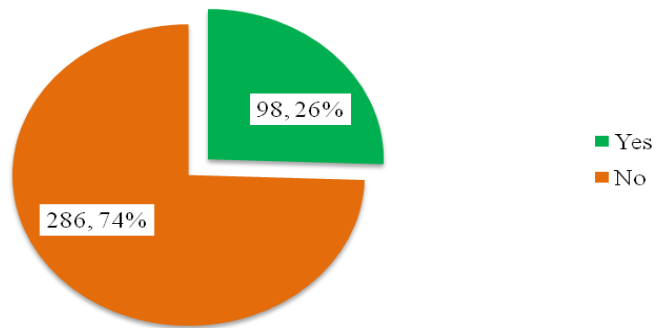
Figure 2: Distribution of knowledge about components of ANC



Varying responses were reported on what they knew about ANC services with outstanding responses being on medical care for pregnant women 69 (18.0%) as well as testing for HIV 58 (15.1%).

4.3 Spousal attendance of ANC

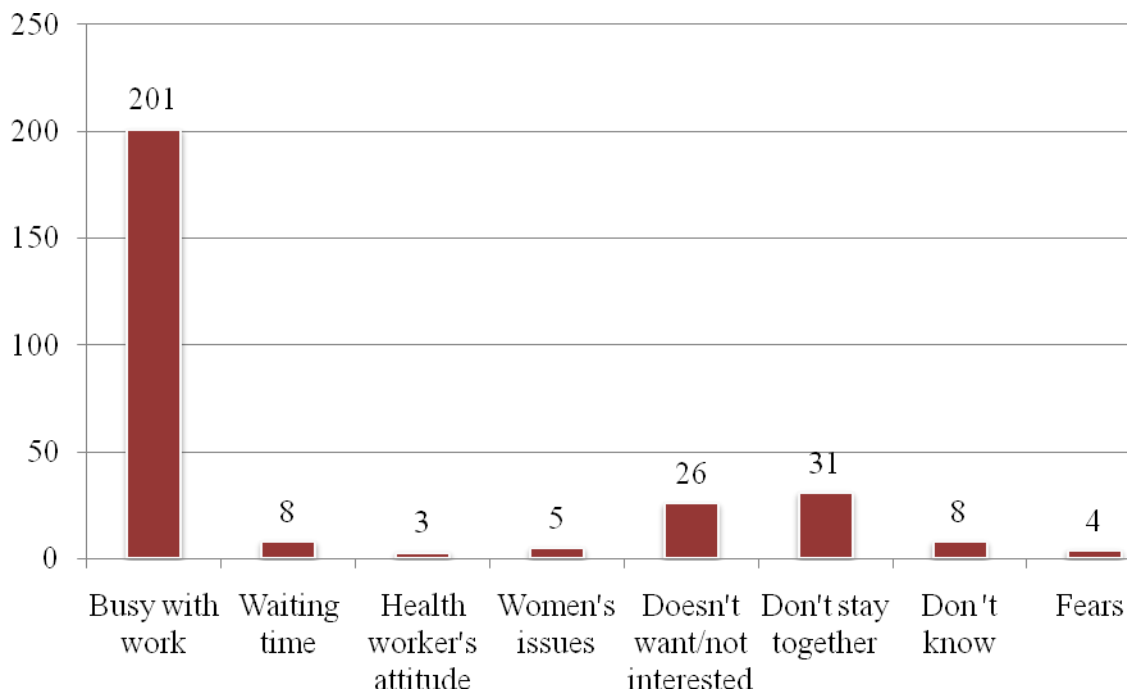
Figure 3: spousal attendance of ANC



Results in figure 3 above show only 98(26%) of the respondents had ever been escorted by their partners to seek ANC services as regards their current pregnancy.

4.3.1 Reasons for non attendance

Figure 4: reasons for non attendance of ANC



According to figure 4 above, being busy with work was the major reason reported by a bigger number of the total respondents 201(52.3%) as one of the reasons for them attending ANC without their spouses.

“When we ask the mothers why they have not come with their partners they tell us that they have gone to work and their bosses do not give them any time off work to attend ANC with their partners.” (KI ANC In- charge at kisugu health center).

4.4 Health system factors

As shown in table 3 below, 311(81.0%) of the total respondents reported that the nearest health facility is either five kilometers or less from their residences. On the other hand, 159(41.4%) of the total respondents reported there are some services that ANC provides for men in order to promote their participation.

On the other hand, 223(58.1%) of the respondents reported they were recognized as a couple by the service providers when they came to the health facility with their spouses.

While long waiting time as a barrier to accessing healthcare services was more pronounced as reflected in the overwhelming responses 115 (29.9%). However, on this matter 103(26.8%) of the total respondents were contented with the services. Challenges faced in attending ANC with their spouses were quite many though outstanding among them were concurrent job demands and long waiting time at the health facility with 79(20.6%) and 63(16.4%) responses respectively.

Table 3: Health systems factors

Health system factors	Frequency	Percentage
Distance to nearest health facility		
Five kilometers and less	311	81.0
More than five kilometers	61	15.9
Don't know	12	3.1
Total	384	100.0
Presence of services that ANC provides for men in order to promote their participation		
Yes	159	41.4
No	63	16.4
Don't know	162	42.2
Total	384	100.0
Dislike about the ANC visit at facility		
Long waiting time	115	29.9
Few health workers	37	9.6
Lack of privacy	5	1.3
Group counseling	14	3.6
Health workers are not friendly	24	6.2
Don't know	12	3.1
Nothing/none	103	26.8
Medication (injection/tablets)	27	7.0
Lack of care	14	3.6
Lack of energy to come	5	1.3
Complications after treatment (appetite loss)	7	1.8
Finding no medicines	21	5.5
Total	384	100.0
Recognition as a couple at this health facility with your partner		
Yes	223	58.1
No	161	41.9
Total	384	100.0

“We give invitation letters to the mothers so that they give them to their spouses as invitations to come for ANC. In addition to this, couples that appear for ANC are served first

so that they leave the facility early hence short waiting time. We think this in turn will prompt the ones who come alone to convince their partners to appear on the next visit.”(KI at Kibuli hospital)

4.5 Bivariate analysis

4.5.1 The individual factors influencing male participation in ANC attendance in Makindye division, Kampala Capital City Authority.

According to results in table 4 below, a number of individual factors had a strong significant influence on male participation in ANC attendance with a p value less than 0.05. Accompaniment by the male spouse to ANC was high among women who were living together ($p=0.000$).

Similarly respondents who had one or two children ($p=0.001$) had an upper hand in ANC attendance. Lastly respondents who had ever attended school with ($p=0.002$) had an influence on male attendance of ANC.

Table 4: Influence of individual factors on male participation in ANC attendance

Individual factors	Partner attended ANC during this pregnancy		X ²	P value
	Yes	No		
Age of respondents in complete year				
18-20 years	27(27.6%)	59(20.6%)	4.719	0.194
21-30 years	61(62.2%)	174(60.8%)		
31-40 years	9(9.2%)	49(17.1%)		
41-49 years	1(1.0%)	4(1.4%)		
Total	98(100.0%)	286(100.0%)		
Marital status				
Never married	23(23.5%)	31(10.8%)	11.024	0.000*
Married	35(35.7%)	108(37.8%)		
Living together	40(40.8%)	143(50.0%)		
Divorced/separated	0(0.0%)	4(1.4%)		
Total	98(100.0%)	286(100.0%)		
Religion				
Protestant	22(22.4%)	46(16.1%)	8.105	0.151
Catholic	28(28.6%)	81(28.3%)		
Pentecostal	14(14.3%)	42(14.7%)		
Muslim	25(25.5%)	58(20.3%)		
SDA	2(2.0%)	17(5.9%)		
Born again	7(7.1%)	42(14.7%)		
Total	98(100.0%)	286(100.0%)		
Number of children				
1-2	48(49.0%)	143(50.0%)	17.231	0.001*
3-4	8(8.2%)	61(21.3%)		
5>	7(7.1%)	4(1.4%)		
Don't have	35(35.7%)	78(27.3%)		
Total	98(100.0%)	286(100.0%)		

Ever attended school

Yes	91(92.9%)	280(97.9%)		
No	7(7.1%)	6(2.1%)	5.680	0.017
Total	98(100.0%)	286(100.0%)		

Highest level of education

Primary	22(22.4%)	84(30.8%)		
O 'level	47(48.0%)	146(53.5%)		
A 'level	9(9.2%)	24(8.8%)	14.589	0.002*
Tertiary	20(20.4%)	19(7.0%)		
Total	98(100.0%)	273(100.0%)		

Fiends who are accompanied by their husbands for ANC

Yes	15(15.3%)	68(23.8%)	3.091	0.079
No	83(84.7%)	218(76.2%)		
Total	98(100.0%)	286(100.0%)		

Encouragement from family

Yes	56(57.1%)	139(48.6%)	2.131	0.144
No	42(42.9%)	147(51.4%)		
Total	98(100.0%)	286(100.0%)		

4.5.2 The socio economic factors influencing male participation in ANC attendance in Makindye Kampala Capital City Authority

Based on results in table 5 below, a number of socio-economic factors showed a strong significant influence on male participation in ANC attendance with ($p < 0.05$). These included type of marriage ($p = 0.002$), and occupation of the respondents ($p = 0.000$). Pregnant women who were in polygamous relationships and those in sales and services based occupations had an influence on male participation in attendance of ANC.

However, the means by which the respondents reached to the health facility; the transport costs and the level of income did not have any statistical significance on male participation in attendance of ANC.

Table 5: Influence of social economic factors on male participation in ANC attendance

	Partner attendance of ANC during this pregnancy		<i>X</i> ²	P value
	Yes	No		
Type of marriage				
Monogamous	74(75.5%)	210(73.4%)		
Polygamous	24(24.5%)	47(16.4%)	12.542	0.002*
Don't know	0(0.0%)	29(10.1%)		
Total	98(100.0%)	286(100.0%)		
Occupation				
Unskilled manual	15(15.3%)	6(2.1%)		
Skilled manual	9(9.2%)	36(12.6%)		
Sales and services	29(29.6%)	88(30.8%)	36.337	0.000*
Professional/Technical	16(16.3%)	20(7.0%)		
Domestic	3(3.1%)	16(5.6%)		
No	26(26.5%)	120(42.0%)		
Total	98(100.0%)	286(100.0%)		
Transport means used				
Walking	24(24.5%)	73(25.5%)		
Bicycle	4(4.1%)	2(0.7%)		
Motorcycle	44(44.9%)	130(45.5%)	6.755	0.149
Public means	26(26.5%)	77(26.9%)		
Private means	0(0.0%)	4(1.4%)		
Total	98(100.0%)	286(100.0%)		
Transport cost to health facility				
<5000/=	59(60.2%)	206(72.0%)		
10,000-20,000/=	11(11.2%)	13(4.5%)	7.469	0.024
Nothing	28(28.6%)	67(23.4%)		
Total	98(100.0%)	286(100.0%)		
Average monthly income				
<250,000	69(70.4%)	150(52.4%)		
250,000-500,000	4(4.1%)	27(9.4%)	10.998	0.012
500,000-750,000	0(0.0%)	5(1.7%)		
None	25(25.5%)	104(36.4%)		
Total	98(100.0%)	286(100.0%)		

4.5.3 The health system factors influencing male participation in ANC attendance in antenatal care service in Makindye, Kampala Capital City Authority

According to results in table 6 below, a number of health system factors showed a strong significant influence on male participation in ANC attendance with ($p < 0.005$).

Respondents who travelled for less than 5km to the health facility were likely to be accompanied by their spouses and this showed a strong significance with ($p = 0.002$). The shorter the distance the higher the chances of being accompanied by the spouse as this comes with low transport costs for the two people and consuming less of the work time on the side of the male partner as reflected in high attendances among respondents who reported five kilometers and less from the health facility.

Recognition as a couple was significant with ($p = 0.005$), attendance was high among respondents who reported being recognized as a couple at the health facility.

However, there was no statistical significance on whether there were services provided for males alongside ANC and male participation ($p = 0.008$).

Table 6: Influence of health system factors on male participation in ANC attendance

	Partner ANC pregnancy	attendance during	of this		
	Yes	No		X²	P value
Distance to nearest health facility					
Five kilometers and less	91(92.9%)	220(76.9%)		12.731	0.002*
More than five kilometers	7(7.1%)	54(18.9%)			
Don't know	0(0.0%)	12(4.2%)			
Total	98(100.0%)	286(100.0%)			
Presence of services that ANC provides for men in order to promote their participation					
Yes	28(28.6%)	131(45.8%)		9.718	0.008
No	17(17.3%)	46(16.1%)			
Don't know	53(54.1%)	109(38.1%)			
Total	98(100.0%)	286(100.0%)			
Recognition as couple					
Yes	53(54.1%)	108(37.8%)		7.984	0.005*
No	45(45.9%)	178(62.2%)			
Total	98(100.0%)	286(100.0%)			
Dislike about the ANC visit					
Long waiting time	28(28.6%)	87(30.4%)			
Few health workers	11(11.2%)	26(9.1%)			
Lack of privacy	1(1.0%)	4(1.4%)			
Group counseling	1(1.0%)	13(4.5%)			
Health workers are not friendly	9(9.2%)	15(5.2%)			
Don't know	2(2.0%)	10(3.5%)		24.097	0.012
Nothing/none	28(28.6%)	75(26.2%)			
Medication (injection/tablets)	4(4.1%)	23(8.0%)			
Lack of care	7(7.1%)	7(2.4%)			
Lack of energy to come	4(4.1%)	1(0.3%)			
Complications after treatment (appetite loss)	2(2.0%)	5(1.7%)			
Finding no medicines	1(1.0%)	20(7.0%)			
Total	98(100.0%)	286(100.0%)			

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter shows how the findings are compared and contrasted with studies done by other researchers in the same area of male participation in attendance of ANC. It also includes opinions, knowledge and inputs from the researcher on the research topic.

5.1 Individual factors influencing male participation in attendance of ANC.

The majority of the total respondents were 21-30 years 235(61.2%) which depicts the population pyramid of the country whereby 52% of the total population comprises of the youth (UNFPA, 2005). This study is in contrast with a study conducted in Cameroon that indicated that older age is associated with male participation Nkuoh *et al* (2010).

Most of the respondents were living together or cohabiting 183(47.7%), followed by those who were married 143(37.2%) and the least were those who were never married 54(14.1%). This is in line with findings of a similar study done in northern Tanzania that found that partners living together were associated with male participation in ANC Msuya *et al* (2008). This is because when couples live together, they are able to support each other and agree in decision making.

This study findings revealed that women who attained high level of education were more likely to be accompanied by their spouses for ANC as compared to those with low education level ($p=0.002$). However, this differs from the study done in Kinshasa where the level of education did not influence male participation (Ditekemena J, 2011). This implies that the

level of education attained by the women plays a big role in couple ANC attendance and the explanation as to why majority of the respondents had their first child between 21 -30 years. In this study, the level of male participation in ANC attendance is low as it stands at 98(26%). While in a similar study conducted in Nepal by Britta *et al* (2004) it was found out that spouses accompanied only 40%(731) of their spouses attending ANC for the first time and that greater decision-making power for women was associated with lower husband accompaniment to ANC and lower overall male involvement. This is attributed to the long waiting time at the health unit coupled with concurrent job demand as reported by 55% (469) in a similar study conducted in Jinja district, Uganda (Nantamu, 2011). The ANC In- charge at Kisugu health center also reported that the men are usually busy with work and therefore find it difficult to get time off duty to accompany their spouses for ANC.

According to the study findings, most respondents 69(18%) reported knowledge of ANC as medical care for pregnant women and HIV screening 58(15.1) as compared to the other reasons. Medical care for pregnant women involves physical examination of the woman and laboratory investigations to find out whether the woman has any problems that need urgent treatment. This also involves health education on the danger signs during pregnancy and how to identify them, including when to urgently return to the health unit.

HIV screening is an important attribute as it contributes to the MoH goal of zero transmission of HIV from mother to child, (MoH, 2006). This also allows for appropriate interventions especially in cases of discordant relationships. This is in agreement with a study done by Olayemi *et al* (2009) in Nigeria which argued that men can participate in helping their spouses stay healthy by making sure that the women get proper antenatal care. This may entail providing transportation or funds to pay for her visits, accompany the wife during

antenatal visits where the man can learn about the symptoms of pregnancy complications and how to respond to an obstetric emergency. This however showed their limitation on knowledge as there are other benefits of ANC apart from the two they mentioned.

This study findings revealed that women who had 1-2 children were likely to be accompanied by their partners for ANC as compared to those who had 2 or more children ($p=0.001$). Findings in a similar study done by Simkhada *et al* (2008) in Nepal revealed that parity negatively influenced ANC attendance which is in agreement with the study findings. This is attributed to the fact that as the women go through their first pregnancy they get support from their spouses but as they gain more experience this ceases to be the case.

However, there was no significant influence between religion, age of the respondents and male participation in ANC. This study is not the case with the study done by Kogan *et al*, (2008) in the United States of America where older men were more likely to attend ANC with their spouses as compared to the young ones. This is attributed to the judgmental nature of some of the health workers towards adolescents spouses which negatively influences teenage male's efforts to participate in ANC Zwelling *et al*, (2004)

5.2 Socio-economic factors influencing male participation in ANC attendance

The study showed that most men in polygamous relationships were associated with male participation in attendance of ANC ($p=0.002$). This finding is in disagreement with findings from another study done in Nigeria revealed that men in monogamous relationships were associated with increased participation in ANC Olayemi *et al*, (2009).

Women who were in sales and services were more likely to be accompanied by their partners for ANC ($p=0.000$). Therefore the level of household income influences ANC attendance as evidenced by studies from Jamaica where by increased household expenditure was associated with joint ANC attendance Gertler *et al*,(2003).

From this study, most of the respondents used motorcycles as a means of transport to the health facility. This is because most health facilities are within a distance of 5km not easily accessible by public means using a taxi. The majority of the respondents used less than 5000 shillings to access the health facility which did not have any influence on male participation in ANC. However the level of income did not have any statistical significance on male participation in attendance of ANC.

5.3 Health system factors influencing male participation in attendance of ANC

According to the study, most of the respondents who resided in distances of less than 5km ($p=0.002$) from the health facility were likely to be accompanied by their spouses for ANC. This is because they are likely to spend less transport to get to the facility as a couple compared to when the services are far and they have to incur more costs. These findings are in contrast to the study done in Jinja district, Uganda which revealed that when services are near, men do not accompany their spouses (MFPED, 2006). This is attributed to the reason that men think providing transport to their spouses to attend ANC is the only reason for accompanying them.

From the study, married partners who were recognized as a couple and served first at the health facility were likely to be accompanied by their spouses for ANC because this would reduce on the waiting time for the man so he can go and do other duties.

Out of the total respondents 115(29.9%) reported long waiting time as a barrier to male ANC attendance. This is in contrast with what the KI, senior midwife at kibuli hospital reported that when couples arrive for ANC, they are worked on first and therefore they spend shorter time at the health facilities. However, this finding is slightly different from that of a study conducted in Gulu, Uganda where waiting time was reported by 23.8% (331) of male respondents as challenges faced while accompanying their partners for maternal health services (Tweheyo,2009).

However, from this study 103(26.8%) of the respondents reported being satisfied with the services at the health facilities. This finding is in contrast with a study conducted in Kenya where poor attitude of service providers was found to negatively influence male partner's involvement in reproductive health services Alka *et al*, (2005). This is attributed to the reason why men do not get involved because they are afraid of being the subject of verbal and emotional abuse, Breiding-Buss *et al* (2002)

The above findings are in contrast to the study done in Uganda by Byamugisha *et al* (2010) which revealed that harsh and critical language towards women from skilled health professionals was a barrier to male participation. In addition to this, some providers do not allow men to access ANC settings which on the other hand makes them believe that they are not recognized as a couple Nkuoh *et al*, (2010). The health care providers should therefore ensure that if people come to access the services as a couple, they should be served as a couple.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

From this study, it is noted that there is low 98(26%) male participation in attendance of ANC. The expectant mothers acknowledged the importance of ANC attendance with their partners as beneficial 349(90.9%). Among their knowledge of ANC were medical care for pregnant women and HIV testing, leaving out other aspects of importance of ANC for example, checking for blood pressure, Tetanus injection, education on breast feeding, general health education, examining for complications of pregnancy and monitoring fetal growth. This shows limited knowledge of the respondents on ANC attendance.

The factors associated with male participation in ANC attendance among the individual factors were level were; level of education at least up to A' level, those living together (cohabiting), those in polygamous relationships, Parity those with 1-2 children.

The socio- economic factors that influenced male attendance of ANC were occupation, those in sales and services and the type of marriage, those in polygamous relationships.

The health system factors that influence ANC attendance were distance to the health facility and recognition as a couple.

However, family and peer influence; level of income, travel cost, and health services for men did not influence male attendance of ANC.

Some of the respondents 103(26.8%) reported being satisfied with the services although long waiting time as a barrier for male ANC attendance was a challenge as well as men failing to get time off work to attend ANC with their spouses.

6.2 Recommendations

MoH should design strategies to empower women and men with knowledge about ANC so as to increase male attendance and not necessarily think that it is about medical care for pregnant women and HIV testing. These messages should be targeted at the facilities and the communities.

Health promotion activities that target men at ANC should be designed and incorporated in all the health education talks at the ANC clinic so that the men do not feel like they are left out.

Fathers 'clubs should be introduced in the health facilities so that the men who attend ANC can meet in these clubs and support each other as they wait for their partners so that their time is actually not counted as loss to them.

Other activities for men like Safe Male Circumcision may be started at ANC settings so that as the men wait for their spouses they are also preoccupied by such services.

Policies should be put in place for employers to allow men with expectant mothers some time off duty so that they accompany their spouses for ANC. This will eventually solve the challenge of spouses not accompanying their wives for ANC.

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APPENDICES

APPENDIX I: CONSENT FORM

Factors influencing Male participation in attendance of Antenatal care in Makindye division, Kampala Capital City Authority.

Purpose of study

The Researcher (Namayanja Annet) is carrying out an academic study on male participation in attendance of antenatal care in the division. The information got from this study will be solely for academic purposes. However, KCCA health department may use it in planning and designing interventions to encourage male participation in antenatal care services. I am therefore requesting you to participate in this research by giving me the information that I need. You are free to withdraw from the study at any time. But I urge you to take part to the end to make the study successful.

I have been told of this study and I understand the objectives of the study as the eventual participation in this study is by choice not coercion. I have understood that I am allowed to withdraw from the study any time I feel like and my withdrawal will not affect my right to access health services from this health facility.

.....

Witness's signature

Participants signature

(Research Assistant) (Thumb print)

Date.....

APPENDIX II: STUDY QUESTIONNAIRE

DISTRICT.....

SUB COUNTY.....

Parish.....

Name of hospital.....

1. Age of respondents in complete year

1=18-20 years

2=21-30 years

3= 31-40 years

4=41-49 years

2. Marital status

1=Never married []

2=Married []

3=Living together []

4=Divorced/Separated []

5=Widowed []

3. Type of marriage

1=Monogamous []

2=Polygamous []

4. Religion

1=Protestant []

2=Catholic []

3=Pentecostal []

4=Muslim []

5=SDA []

6=Other []

5. Occupation

1=Unskilled manual []

2=skilled manual []

3=Sales and services []

4=Professional/Technical []

5=Domestic []

6. Distance to nearest health facility

1=Five kilometers and less []

2=More than five kilometers []

3=don't know []

7. Have you ever attended school?

1=Yes []

2=No [] if No skip to Qn 9

8. If yes, what is the highest level of education that you achieved?

1=Primary []

2=O 'level []

3=A' level []

4=Tertiary []

9. What is your main source of knowledge about health issues?

1=Radio []

2=VHT member []

3=Health worker []

4=Community campaign []

5=other

(specify).....

10. What transport means do you usually use?

1=Walking []

2=Bicycle []

3=Motorcycle []

4=Public means []

5=Private means []

11. What do you know about ANC services? [**Tick all responses that apply**]

1=Medical care for pregnant women []

2=Testing for HIV []

3=Testing for syphilis []

4=Monitoring growth of unborn baby []

5=Examining for complications of pregnancy []

6=Planning place and/ type of delivery []

7=Nutrition education to the pregnant woman []

8=General health education []

9=Education on breast feeding the baby []

10=providing education to the pregnant woman []

12. Has your partner ever attended ANC during this pregnancy?

1=Yes []

2=No []

13. If no, why did he not attend ANC with you

.....
.....
.....

14. What do you like about the ANC visit?

1=HCT []

2=STD screening []

3=Sex education []

4=Nutrition education []

5=Birth preparation []

6=other (specify) [].....

15. What did you dislike about the ANC visit?

1=Long waiting time []

2=Few health workers []

3=Lack of privacy []

4=Group counseling []

5=Health workers are not friendly

6=other (specify) []

16. What challenge did you face in attending ANC with your partner?

1=Lack of transport []

2=Long distance to health facility []

3=Lack of knowledge of importance of participation

4=Concurrent job demands []

5=Long waiting time at the health facility []

6=Limited services for men at ANC []

7=other (specify) [].....

17. Do you consider attending ANC with your partner as beneficial?

1=Yes []

2=No []

18. In your opinion, what are the benefits of attending ANC with your partner?

1=Fetal growth monitoring []

2=Medication to avoid infections from mother to baby []

3=HIV screening []

4=STD screening []

5=Identification of complications in pregnancy []

6=Involvement in decision making about the baby []

7=other (specify) [].....

Thank you

APPENDIX III: KEY INFORMANT INTERVIEW GUIDE

Name of the Facility

1. Gender (Male/Female- tick appropriately)
2. Age.....
3. Designation.....
4. Number of years in the service.....
5. Number of years at the present Office.....

Antenatal care (*Tick the available ones*)

No	Services	Yes	No
A	Screening and risk assessment through; <ul style="list-style-type: none"> - history taking - general abdominal examination - investigations - vaginal pelvic examination where applicable - STIs including HIV 		
B	Provision of haematemics (iron tablets and folic acid)		
C	De-worming		
D	Immunization against TT		
E	Intermittent Presumptive Treatment of Malaria		
F	Early recognition, management and referral risk mothers and those who develop complications		
G	Develop a delivery and postpartum care for every woman		

1. Do you have any programs targeting male involvement in reproductive health in this facility? If yes, please explain

.....

.....

.....

.....

.....

.....

2. How does the facility encourage male participation in ANC?

.....

.....

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.....

.....

3. What health system factor does the facility have/plan to put in place in order to further encourage male participation in safe motherhood services?

.....

.....

.....

.....

.....

4. What could be the reasons that prevent men to accompany their wives for preconception care, ANC?

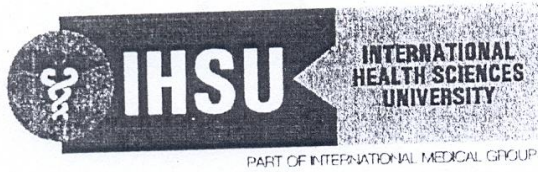
.....
.....
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.....

5. What do you suggest that the health service managers and the health workers in KCCA need to do to encourage male involvement in ANC services?

.....
.....
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.....
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.....
.....

Thank you.

APPENDIX VI: INTRODUCTORY LETTER



Office of the Dean, Institute of Health Policy & Management

Kampala, 18th September 2014

TO THE TOWN CLERK
MAKINDYE DIVISION
KCCA

Dear Sir/ Madam,

Re: Assistance for Research

Greetings from International Health Sciences University.

This is to introduce to you **Namayanja Annet, Reg. No. 2011-BSCPH-PT-049** who is a student of our University. As part of the requirements for the award of a Bachelors Degree of Public Health of our University, the student is required to carry out field research for the submission of a Research Project.

Namayanja would like to carry out research on issues related to: **Factors Influencing Male Participation in Attendance of Antenatal Care in Makindye Division, Kampala Capital City Authority**

I therefore request you to render the student such assistance as may be necessary for her research

I, and indeed the entire University are thanking you in anticipation for the assistance you will render to the student

Sincerely Yours,

Prof. David Ndungutse Majwejwe
Dean, Institute of Health Policy & Management

International Health Sciences University
P.O. Box 7782 Kampala | Uganda | East Africa
Tel: (+256) 0312 307 400 | E-mail: info@ihsu.ac.ug | web: www.ihsu.ac.ug

APPENDIX V: AUTHORIZATION LETTER



Ref/MKD/KCCA/ 505

Wednesday, October 01, 2014

The IN Charges
Health Facilities
Makindye Division

RE: ASSISTANCE FOR RESEARCH – MS ANNET NAMAYANJA

Ms Annet Namayanja is a student of International Health Sciences University reg. no. 2011- BSCPH – PT – 049. She would like to conduct a research on issues related to “ Factors Influencing Male participation in Attendance of Antenatal Care in Makindye Division – Kampala Capital City Authority.

The information she intends to get is only for academic purposes and no other.

This is therefore to request you to render her the necessary assistance in that regard.

A handwritten signature in black ink, appearing to read 'Tibihika Theo', is written over a faint, rectangular stamp. The stamp contains the words 'CITY' and 'COUNCIL'.

Tibihika Theo
Town Clerk – Makindye Division

P. O. Box 7010 Kampala- Uganda
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Tel: 0414 231 446 / 0204 660 000
Web: www.kcca.go.ug. Email: info@kcca.go.ug
f. [facebook.com/kccaug](https://www.facebook.com/kccaug). t. @KCCAUG