THE FACTORS FOR LOW PARTICIPATION OF MALE PARTNERS IN ATTENDING ANTENATAL SERVICES IN JUBA TEACHING HOSPITAL, SOUTH SUDAN

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DEDICATION

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ABBREVIATIONS AND ACRONYMS

AIDs	Acquired immunodeficiency syndrome
ANC	Antenatal Care/Clinic
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPTP	Intermitted preventive treatment for malaria during pregnancy
JTH	Juba Teaching Hospital
MDGs	Millennium Development Goals
NASCOP	National Aids &STIs Control Program
PMTCT	Prevention of Mother-to-Child Transmission of HIVAIDS
PMNCH	Partnership for maternal, New born and Child health
PNC	Post-natal care
UNICEF	United Nations International Children Emergency Fund
UNFPA	United Nations Population Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

ABSTRACT

Male participation in the Antenatal services is crucial for realization of socio-cultural and economic development especially through their participation as couples in the uptake of antenatal care for an improved maternal health. This study sought to explore the factors for low male partner participation in attending antenatal services in Juba Teaching Hospital, South Sudan. It identified antenatal services offered, the benefits of attending antenatal services by both partners, the causes of low participation of male partners in antenatal services and the strategies for enhancing the participation of male partners in antenatal services in Juba Teaching Hospital

This research useda case study designin which qualitative data was collected. Data was obtained by means of questionnaires and interview guides through which primary data was collected. Secondary data was also collected from documented information to support primary data. By means of simple random and purposive sampling techniques a sample of 50 respondents was drawn from male and female partners married with children, married and expecting, and officials in the department of the antenatal clinic at Juba Teaching Hospital in order to explore the views on why the husbands don't attend clinic '2appointments. The data collected was processed, coded and analyzed qualitatively

The study found the following. The antenatal services offered by Juba Teaching hospital included; Antenatal checkups,Counseling and guidance, Antenatal care training, and STD/HIV/AIDS counseling and testing. The study also found the following benefits of attending antenatal care; Updates about progress of pregnancy, Test for HIV/AIDS, Responsibility/support, and health security reasons. The causes of low male partner participation in antenatal services found include; fear of being discovered HIV/Aids positive, financial constraints (poverty), and Cultural believe that its women's responsibilities.

The researcher however concluded that there was need for the facility especially the clinic area to improve in terms of space and sitting arrangements to accommodate all mothers and their spouses comfortably and add more health workers to facilitate quick and quality services to the clients. The researcher also felt the need to advocate for policy change so that the government can pass laws which oblige male partners to be responsible for their unborn babies and their pregnant partners especially financially and emotionally. The other service providers such as NGOs should embark on sensitizing the public on role of both parents in children upbringing.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

The attitudes and beliefs of men affect the maternal health outcomes of women and their babies. Excluding men from maternal health care services could lead to few women seeking maternal health services and as a result worsening the negative maternal health outcomes for both women and babies. Understanding the factors affecting male involvement in antenatal care services in Juba County is important in order for health service managers and health workers to design interventions that will encourage and maintain male participation. The focal point of this study was to explore factors for low participation of male partners in attending antenatal services in Juba Teaching Hospital in South Sudan. This chapter constitutes the background to the study, the problem statement, the objectives of the study and research questions, as well as the scope and significance of the study.

1.1 Background to the Study

Antenatal care refers to the regular medical and nursing care recommended for women during pregnancy. It is about Identification and surveillance of the pregnant woman and her expected child (WHO 2010). The woman under takes screening for conditions and diseases such as anemia, STIs (particularly syphilis), HIV infection, mental health problems, among others. ANC came late 1930s when the United Kingdom of Great Britain and Northern Ireland authorities decided that all women should be offered regular checkups during pregnancy as an integral part of maternity care in order to address the health issues stated above. Pregnant women are expected to have a series of appointments with a midwife, or sometimes with a doctor who specializes in pregnancy and birth (an obstetrician). They will check that a woman and her infant are well, give woman and her

husband useful information to help them have a healthy pregnancy (including healthy eating and exercise advice) and answer any questions they may have (WHO 2010)

According to Thaddeus and Maine (1994) men's participation in antenatal services is a responsibility by looking for care and being able to transport the pregnant women to obtain health services. Antenatal services is a form of defensive care with the aim of providing consistent check-ups that permit doctors or midwives to treat and avoid possible health issues during the course of the pregnancy while encouraging healthy existences that help both mother and baby. Throughout check-ups, women will get medical information over maternal physiological changes in pregnancy, biological changes, and prenatal nutrition including prenatal vitamins. Recommendations on management and healthy existence changes are also made during regular check-ups (Aluisio, et al., 2011).

Globally, it is believed that when men participate in antenatal services, it facilitates women's empowerment that leads to attainment of equal access to health. The failure to incorporate men in antenatal care by policy makers, program planners and implementers of maternal health services has had a serious impact on the health of women and babies (Greene et al., 2002).
In South Africa, as in most other African countries, family planning, pregnancy and childbirth have long been held as totally women's affairs. Men commonly do not escort their partners to family planning, antenatal services and are not expected to attend the labour or birth of their children. However, male dominance generally and in sexual relations can put women at serious risk of unwanted pregnancy and infection; in pregnancy, male sexual behaviour can affect the health outcomes of both mother and baby(WHO,2007)

Men's lack of participation at antenatal services means that they do not value any information given by health workers, regarding the

health of mother and baby, or about their role in it. Men are rarely exposed to clinic reproductive health services as they tend to seek care for sexually transmitted infections in the private sector, and condoms can be got from clinics without contact with providers. The issue of accessibility of reproductive health services to men in South Africa is a logistical and cultural problem. The exclusive use of services by women has, to a great extent, made antenatal services unfavorable for men.

Male participation in the antenatal services clearly goes against prevailing gender norms in many places in Sub-Saharan Africa. Reproductive health seeking was seen by men as "women's work". Men saw the antenatal services as women's space, and the definition and organization of the program as basically female oriented (Reece, et al., 2010). Probably, men thought that antenatal services activities fell outdoor their area of duty. As a result, men alleged that attending the antenatal clinic would be "unmanly".

According to Byamugisha, et al. (2010), there are different factors which have been identified in other studies as barriers to male participation in the antenatal services and they include: Health-facility factors, Cultural factors and Socio-Economic factors. The failure to include men in maternal health promotion, prevention and care programs by policy makers, program planners and implementers of maternal health services has had a serious impact on the health of women, and the success of programs (Greene, et al., 2002). Yet the huge majority of African women are still ignorant of their ultimate rights to health and they endure to suffer from socio-economic discrimination and undesirable pregnancies which are destructive to their health.

The United Nations expert group on women and finance projected that 70 percent of the world's population living on less than a dollar a day is women (Were, 2009). Women tend to have less education and have fewer job opportunities, which affect their maternal health seeking behavior and maternal health results. Male participations in antenatal services may help decrease unplanned pregnancies and

transmissions of sexually transmitted infections as well as improve child survival.

According to a South Sudan National program report (2014), male partners' participation in the antenatal clinic by region was as follows: Yei 3%, Ezo 5.3%, Juba 5.2%, Upper Nile 4.6%, Eastern 6%, Rumbek 3.4%, Yambio 6.4% and Wau 2%. The average male participation in South Sudan being 5.1%. Thus, there is low male partners' participation in South Sudan.

However, studies conducted on factors influencing low participation of male partners in antennal services in Juba Teaching Hospital is lacking. Therefore, identifying and overcoming factors influencing low participation of male partners in antennal services requires working with women, young people and men to understand better their needs and analyze their problems and to propose acceptable solutions.

JTH, being a referral hospital, receives many mothers in the antennal services from all over the country. There are mothers who come from the rural areas to join their spouses who live in Juba at the same time receiving health care services in this hospital. However, only a few are escorted by their husbands to the clinic to avoid getting lost in the city. The antenatal clinic also receives clients from the low income class since there is a consultation fee to be paid during every visit which many from low income class may not afford. Again their spouses have busy working calendar, this could limit one from attending antennal services which this study is trying to explore.

1.2 Statement of the Problem

Male participation in Antenatal services has multiple benefits including for HIV prevention and treatment in that the men will also understand the complications of pregnancy which will make them respond appropriately when they arise. Men can encourage their wives who are likely to forget and skip their schedule visits.

According to the South Sudan's Ministry of Health's quarterly reports on male uptake of antennal service at Juba Teaching Hospital (JTH), the records for 2009-2010 was 3078 (34%), whereas for October 2011 to September 2012 was 1694(29%) and for October 2012 to September 2013, 1372(24%)(South Sudan National Program 2014). This shows a low and declining trend which needs to be addressed. In Juba Teaching Hospital out of the 10 pregnant women who visited the facility and queued to fill in the light green antenatal cards, only 3 were escorted by their husbands. The Director General for Reproductive Health in the National Ministry of Health, Dr. Alex Dimiti in an interview with Gurtongon 28th July 2016further noted that "in a day, only eight or ten show up at the centre with their wives. Most men feel a shamed to escort their wives here".

Donor agencies, both local and International have worked hard to increase male partners' participation in antenatal services in respect to reproductive health globally. Despite the efforts to improve participation of men in antenatal services the rate of participation still remains low at 5.1% in South Sudan (Brusumento,Ghanotakis,Tudor, VanVelthoven,MajeedandCar,2012).The low participation of men in antenatal services will mean that: Only few women will have access to maternal health services, consequently this worsens the maternal health outcomes for women and children(Nkuoh 2010; WHO, 2014). To contribute to the situation of this challenge, this research will explore the reasons why there is low participation of male partners in attending antenatal services in Juba Teaching Hospital in Juba County, South Sudan.

1.3 Objectives of the Study

1.3.1 General Objective:

The main aim of the study was to explore factors for low participation of male partners in attending antenatal services in Juba Teaching Hospital.

1.3.2 Specific Objectives:

The specific objectives were as follows:

i. To identify antenatal services offered in Juba Teaching Hospital
ii. To identify the benefits of attending antenatal services by both partners in Juba Teaching Hospital
iii. To identify the causes of low participation of male partners in antenatal services in Juba Teaching Hospital.
iv. To identify the strategies for enhancing the participation of male partners in antenatal services in Juba Teaching Hospital

1.4 Research Questions

The study sought to answer the following questions:

ι. What antenatal services are offered by Juba Teaching hospital?
ιι. What are the benefits of attending antenatal services at JTH?
ιιι. What are the causes of low male partner participation in antenatal services in Juba Teaching hospital?
ιϖ. What strategies can be used for enhancing participation of male partners in antenatal services?

1.5Scope of the Study

This study was confined to the following spheres:

1.5.1 Content Scope:

The study focused on exploring the factors for low participation of male partners in attending antenatal services in Juba Teaching Hospital. In particular, the study identified antenatal services offered in TJH, the benefits of both partners attending antenatal services. It also explored causes for low male partners in

attending antenatal services in Juba Teaching Hospital and established strategies to enhance male partner's participation in the attending antenatal services.

1.5.2 Geographical Scope:

Juba is the capital and the largest city of the Republic of South Sudan. It serves also as the capital of Jubek state, one of the 28 states of South Sudan. It functions as the seat and metropolis of Juba city. The study was carried out in Juba city and at the Juba Teaching Hospital. Juba Teaching Hospital (JTH), a 580-bed facility located in Juba City, along Malakia Juba International Airport Road, built in 1916 by Missionaries. It is the only major referral hospital in the whole country of South Sudan. JTH offers the following inpatient and outpatient services: Pediatrics, Surgical – operations, Maternity, Laboratory, Medical clinical, ANC and PMTCT services, Immunization programs and HIV/AIDS therapy.

1.5.3Time Scope:

This study established the factors for low participation of male partners attending antenatal services over the past five years (2011 to 2015). It examined the interventions so far implemented in encouraging male partner participation in antenatal services. It examined this in line with the South Sudan National Health Strategic Plan of 2011 – 2016 focus on improving maternal health

1.6 Significance of the Study

The study is expected to contribute to the issue of male partner participation in antenatal services along the following:

The findings of the study will help the government to advocate for policies which can help boost male partner participation in antenatal services together with their wives.

The findings of the study will act as a litmus test of all the various programs that have been put in place in an attempt to increase male partner participation in the access and utilization

of antenatal services and to answer questions about the extent to which it has been executed including the reasons for its current status. This will help build South Sudan National Health Strategic Plan of 2011 – 2016 focus on improving maternal health and beyond.

The findings of the study will help policy makers and all stakeholders in drawing appropriate responses to instances of low male partner participation in antenatal care services.

The study will enable the researcher to acquire practical research skills as well as act as a partial fulfillment of the requirements for the award of a Bachelor's Degree in Democracy and Development Studies of Uganda Martyrs University - Uganda.

1.7 Justification of the Study

Although there is no statistics showing the extent of the problem and evidence, every pregnancy in Juba County faces an element of risk. Men, as partners and decision makers, need to be involved in antenatal services. Low male participation in antenatal services results in low utilization of ANC, health facility delivery. Men's accompanying their wives in routine ANC and other antenatal services is an important factor in contributing to the reduction of maternal morbidity and mortality. 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 get health services. Men accompanying women for antenatal care presents an opportunity to the health workers to educate them and empowering men to make suitable decisions and actions that may influence the outcome of the pregnancy.

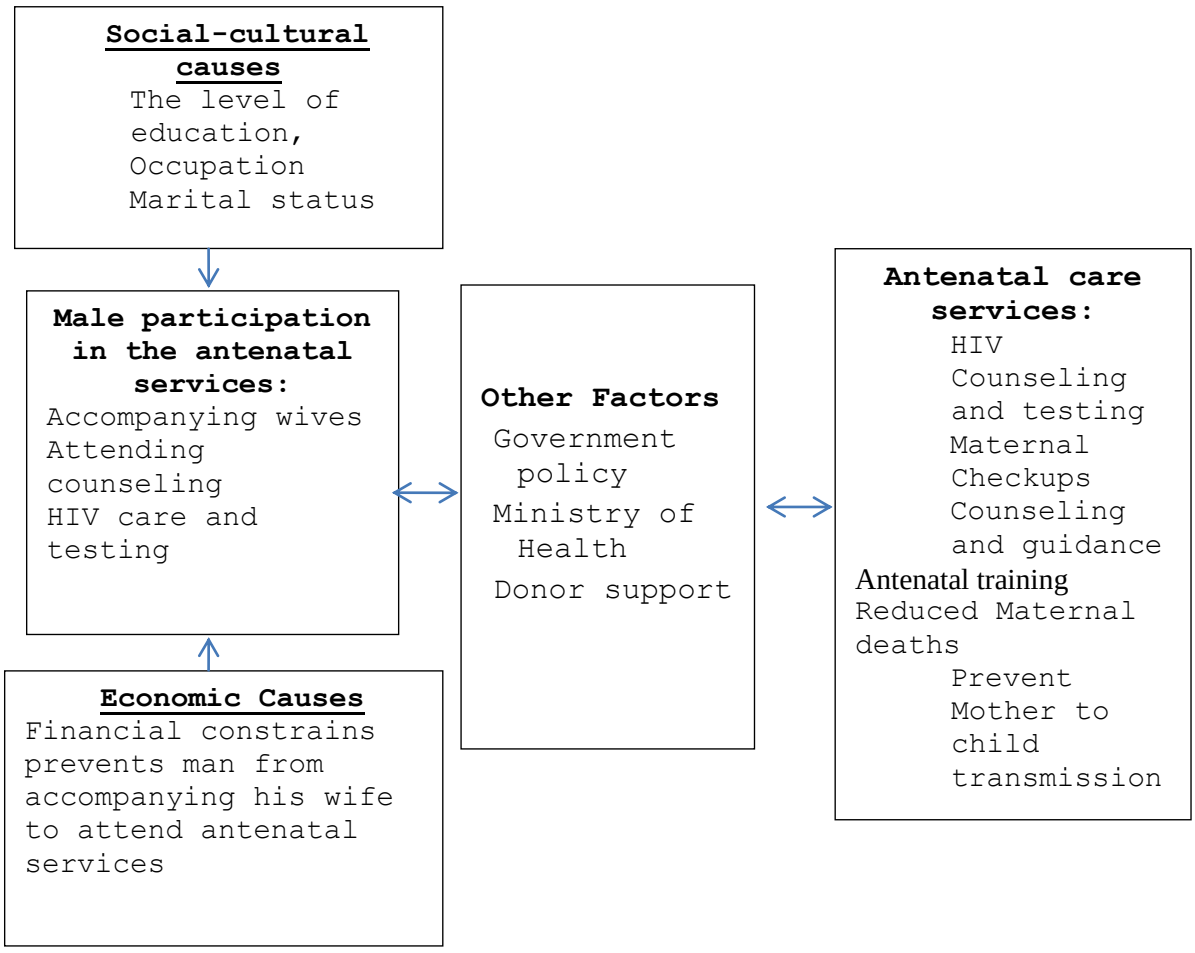
This study was therefore, important to undertake in order to contribute to improvement of the factors that make men get involved in antenatal services. Information generated will be used to provide decision-making and actions that will lead to increased male participation in antenatal services. Increased male

participation in antenatal services will subsequently, lead to increased use of maternal health services by the pregnant women, mothers and their children in Juba County.

1.8 Conceptual framework

The study was carried out basing on the interrelations between the concepts in the research problem. It explored the connection between the antenatal services and male partner participation the antenatal services as explained below.

Figure 1.1: Showing the Conceptual Framework



A man's partaking of antenatal services may be influenced by his socio-cultural characteristics like age, educational level and occupation, the nature of marital union (formally married, unmarried or cohabiting), and whether or not they live together may also be central reasons in shaping the level of participation. Cultural norms that segregate gender roles may not encourage men to

take part in activities that are tagged as feminine. Other family associates like mothers and mothers' in-laws may be seen as the ones answerable for issues related to pregnancy and delivery and so men may be hesitant to get involved (Adeleye and Parakoyi, 2011). This means that cultural norms and practices directly affects male partner participation and this cultural belief influences the financial demands on the male partners to provide for the women (the belief that men are the bread winners) and this consequently affect male partner participation. Such norms and believes can only be overcome by strengthening policies and increased awareness creations.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter deals with the review of related literature of the study. Past studies done on male participation in the antenatal services were reviewed to identify the existing gaps which the study tries to address. The conceptual model is to discuss and give a good highlight. It explores the findings of various authors and examines the applicability of their findings in relation to the present study.

The goal of maternal health care services is to ensure that no woman or newborn dies or incurs injuries due to pregnancy and or childbirth. However, to achieve this goal, maternal health service planners, service managers and providers need to view maternal health services in the context that women's potential to control and improve their wealth as well as their health is more limited than men's in most parts of the world (Engender Health, 2008). This prevents women from accessing critical health information and services and can lead to poor reproductive, maternal and child health outcomes, including unwanted infections and unwanted pregnancies.

For men have a strong influence on women's health and their access to care, the need for male involvement in maternal health services is clear and male involvement is becoming even more critical in the delivery and uptake of maternal health care service. According to Adamehak and Adebyao (1997), in order to encourage improved reproductive health, emphasis needs to be focused on the understanding of men's reproductive behavior and the influence to their wives.

2.1 Antenatal Services

The safe motherhood initiative, launched in 1987 by WHO, UNICEF, UNFPA, the World Bank and other organizations placed maternal health at the forefront of international public health (Family care international, 1997) Maternal health is a state of complete physical, mental and social well-being of the mother; it is a resource for everyday life of the mother. Maternal health care services comprise of a wide range of health services given to the mother before pregnancy, during pregnancy, labour and after delivery. Maternal health services include the following, preconception care, antenatal care (ANC), Prevention of Mother to Child Transmission of HIV (PMTCT), safe delivery (intra-partum care); post-natal care (PNC) and emergency obstetric care/management of obstetric complications. However, for this study maternal health services refers to antenatal care, delivery and postnatal care

2.2 Benefits of Attending Antenatal Services

According to Nungari(2014), it is important to note that both husband and wife as well need to understand and appreciate the discomfort and tiredness that pregnancy may cause to the pregnant woman. The awareness about the demands of pregnancy on the part of the husband and other family members could result into the necessary support the pregnant woman needs from the family members including the husband. The key elements of the birth plan package include recognition of danger signs, a plan for a 9 birth attendant, a plan for the place of delivery, and saving money transport or other costs in case the need arises (Nungari, 2014). In addition, for birth preparedness, a potential blood donor and decision-maker (in case of emergencies) need to be identified. This is because complications such as hemorrhage are unpredictable and highly fatal if timely treatment is not obtained.

Essential interventions in antenatal services include: identification and management of obstetric complications such as

pre-eclampsia, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy (IPTp), and identification and management of Infections including HIV, syphilis and other sexually transmitted infections (STIs). ANC is also an opportunity to promote the use of skilled attendance at birth and healthy behavior such as breastfeeding, early postnatal care and planning for optimal pregnancy spacing.

Globally, low male involvement in maternal health care 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 (WHO, 2007). At the 1994 ICPD in Cairo the participating nations (179 nations) 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 on issues of sexuality and reproductive health" (UNFPA, 2004

In sub-Saharan Africa, pregnancy and childbirth continue to be viewed as solely a woman's issues. A male companion at antenatal care is rare and in many communities, it is unthinkable to find male companions accompanying a woman to the labour room during delivery. However, men have social and economic power, especially in Africa, and have tremendous control over their partners. They decide the timing and conditions of sexual relations, family size, and whether their spouse will utilize available health care services. Hence this situation makes male partner involvement critical if improvement in maternal health and reduction of maternal morbidity and mortality is to be realized.

Strategies for involving men in maternal health services should aim at raising their awareness about emergency obstetric conditions, and engaging them in birth preparedness and complication readiness. Male involvement will enable men to support their spouses to utilize emergency obstetric services early and the prepare for

birth and ready themselves for complications. This would lead to a reduction in all three phases of delay and thereby positively impact birth outcomes (kakaire, et al, 2011)

Studies have shown that men who are educated about reproductive health issues are more likely to support their partners in contraceptive use, use contraception themselves, and demonstrate greater responsibility for their children (Grady et al. 1996). More importantly, women express great interest in wanting their partners to be involved in joint reproductive health decision-making. For example, a study in Ecuador surprisingly showed that 89% of women wanted their partner to accompany them on their next family planning visit and 94% would have liked their partner to be present during their family planning session (Roy & de Vargas Pinto, 1999; Mehta, 2002). Studies have suggested that male involvement in maternal health results into positive outcome for not only the pregnant woman but also for the unborn child. Reporting findings of their studies (Pagel et al., 1990 and Mutale et al., 1991), concluded that lack of social support especially from the husbands or family has negative effects on fetal growth.

In much poorer countries many of which have a patriarchal society, increase in male involvement during pregnancy has been seen as a possible factor in reducing the number of children born with low birth weight (Mira and UNICEF, 2000). However, despite these benefits of male involvement in maternal health care services, the majority of interventions and services to promote SRH including care during pregnancy and childbirth in most countries have been exclusively focused on women (Ntabona, 2002). Yet it is important to assume that for all the steps leading to maternal survival there is always a man standing by the side of every woman knocking at the gate, before, during and after each pregnancy (WHO, 1995).

Some 24 studies from peer reviewed journals; 21 from sub-Saharan Africa, 2 from Asia and 1 from Europe identified barriers to male involvement as mainly at the level of the societal perception of

antenatal care (ANC) as a woman's activity, and it was unacceptable for men to be involved, the health system factors such as long waiting times at the ANCS and the male unfriendliness of ANC services were also identified. The lack of communication within the couple, the reluctance of men to learn their Human Immunodeficiency Virus (HIV) status, the misconception by men that their spouse's serostatus was a proxy of theirs, and the unwillingness of women to get their partners involved due to fear of domestic violence, stigmatization or divorce was among the individual factors.

According to World Health Organizations (WHO, 2007), the Partnership for Maternal, Newborn and Child Health (PMNCH) reports showed that in Swaziland, HIV prevalence among pregnant women attending ANC arose from 4% in 1992 to 43% in 2004 and that each 11 day, 1800 children worldwide become infected with HIV, the vast majority of them newborns. Therefore, in this regard, PMNCH works to invest, deliver and advance to save lives of women and young children with HIV/AIDS.To achieve all these fundamental goals effectively and quickly, investing in the education and involvement of men during/after pregnancy and in programs for mothers living with HIV.AIDS is very crucial. Moreover, there is need to advance the engagement of men in the ANC as PMTCT efforts may fail without their support.“When men test, adherence to PMTCT may increase” (Msuya et al. 2008). One study has demonstrated a reduction in HIV-associated infant mortality and poor feeding options (Aluisio et al., 2011). Male-partner involvement may also lower transmission risk to sexual partners, which has been shown to be greatest within established partnerships (Dunkle et al., 2008), and increased during pregnancy (Mugo et al., 2011).

In a study which examined the male spousal participation in Western Kenya, of 2104 pregnant women who accepted voluntary counseling and testing (VCT), 15% of these women and their male spouses received testing, while only 5% of couples received counseling together (Farquhar et al., 2004). Male partner support has been shown to be a crucial component in facilitating women’s ability to accept

preventive interventions. Women who disclosed their HIV status to their partners were more likely to return for post-test counseling, three times more likely to adhere to their ARV prophylaxis/ treatment during pregnancy and at the time of delivery, and five times more likely to adhere to prescribed breastfeeding protocols, accept and modify infant feeding practices and increase condom use in the postpartum period than those who did not (Farquhar et, al., 2004).

Men are clearly requesting for more participation in the childbirth process. It is also interesting to note how, in a recent survey on men and work, 75% of the men would accept slower career advancement if they could have a job that would let them arrange their work schedule to have more time with their families. At the prospect of becoming a father, men are filled with excitement, fear, wonder, worry, love, and confusion. Throughout the pregnancy and birth, the man, who is now becoming a father, is trying to find ways to express and integrate these and many more feelings. In contrast, other programs have been successful in achieving greater participation of couples during expanded weekend hours (Allen et al., 2003).

By giving women open and active support, men can also clearly positively affect women's attitude towards pregnancy (Kroelinger andOths, 2000). During pregnancy and delivery men can give vital mental and emotional support to the women (There are evidences suggesting that men's presence in the labor room shortens the period of labor and reduce the number of children ever born with low birth weight (Dudgeon and Inhorn, 2004). Byamugisha et al. (2010), scored male involvement using 6 variables: The man accompanying his wife during ANC services; knowing the ANC schedule; discussing the ANC interventions with the female partner; supporting the ANC fees; Knowing what happens at the ANC and Using a condom with the female partner during the current pregnancy. Scores between 0–3 were considered weak male involvement and scores

of 4 and above were considered as high male involvement. While this scoring system is a useful first step, it remains to be validated

2.3 Causes of Low Participation of Male Partners in Antenatal Services

Social scientists have made important steps in shedding light on the basic social and cultural structures and procedures that influence health. Social and cultural factors influence health by affecting exposure and weakness to disease, risk-taking behaviors, the effectiveness of health raise efforts and access to, accessibility of, and value of health care. Social and cultural factors also play a role in determining insights of and answer to health problems and the influence of poor health on individuals' lives and well-being. In addition, such factors contribute to sympathetic societal and population processes such as current and changing rates of morbidity, survival, and mortality. (National Institute of Health, 2014)

According to a survey done in Mbale regional referral hospital in rural Eastern Uganda and other studies, the following factors were cited as the barriers to male participation. Most studies reported that older age and cohabiting were associated with male participation. A group conducted a study in Kinshasa and found male participation was 1.2 times higher among men whose female partners were 25 years or older. Monogamous partners and cohabiting men were twice and 1.6 times respectively more likely to be involved. In contrast, Nkuoh et al. (2010), reported that Cameroonian men in polygamous relationships showed higher involvement.

A study in Uganda found that men who had accomplished 8 or more years of education were twice more often involved compared with those with less than 8 years of education. This was not confirmed in a study in Kinshasa where the level of education of 13 pregnant women or their male partner did not influence male participation.

In Uganda, taxi drivers and "Bodaboda" riders (motorbike taxi riders) were less likely to participate than men with other professions such as farmers or construction workers. Reece et al. reported that Kenyan men having only an occasional job were less likely to participate in MCH services. Another study from Rwanda reported that men with a well-paid job were more likely to participate in PMTCT interventions compared to those not well paid.

In several studies cultural standards were identified as barriers for male participation. Several studies have stated undesirable insights towards men attending antenatal services. In one report, men who escorted their wives to antenatal services were perceived as being dominated by their wives or weaklings by their peers. Frequently men perceive that ANC services are designed and reserved for women, thus are embarrassed to find themselves in such "female" places. Some men believe it is not good to follow your wife to the antenatal clinic even though she exposed her privacy to you at home and that male participation in ANC services is superfluous and that ANC is "a woman's responsibility" (Byamugisha et al., 2010). Certain women too, do not like to be seen with their male partner attending the ANC service. A study conducted in Kenya presented that certain male clients trust traditional healers but not hospitals and therefore do not attend ANC clinics.

Fear of receiving a HIV positive result and privacy concerns stop some men from coming for ANC. In many studies men were cited being worried about HIV-associated stigma and disclosure. Men may be afraid of HIV status disclosure in a health system facility, in the context of weak health system. In another study, women said that engaging their partners in antenatal services would be particularly challenging if men were unaware of their status, refused to be tested, or were in denial about their HIV status (Reece et al., 2010). There also seems to be a gap in knowledge related to discordancy. Some men questioned the need for testing if their partners had already been tested, believing that they would have the same test results as their partners (Falnes et al., 2011). Men

also feared discordancy because of the anger and bitterness it could cause in the relationship.

Gender-based violence is another cause of low male involvement. Victims of gender based violence may be afraid to ask their partner to be tested for HIV. Several studies also have showed that women at ANC clinics fear violence from their partners who attend ANC clinics with them. These women feared how their partners would react after the discovery of a positive HIV test result which may lead to rejection, loss of economic support, fear of stigmatization, denial, discrimination, violence, upsetting family members, and avoiding accusations of infidelity (Medley et al., 2004).

Alcohol use is recognized as another factor for non-participation of men. Daily overconsumption of alcohol by male partners maybe particularly implicated as a catalytic event for physical violence towards women. In similar regard, Karamagi reported alcohol as one of reasons for 54% of lifetime partner's violence and 14% of physical violence in Uganda. Ntanganira found the 35.1% of intimate violence in the last year; physical violence was twice likely to occur if a woman was HIV positive than negative.

Poor communication between men and their female partners was associated with poor male participation. On the other hand, good couple communication was associated with high seropositive status disclosure and support between husband and wife. For example, in this study the focus of participation of men in antenatal care is on their readiness to provide support to their female partners in core interventions which include counseling and testing, use of prophylaxis antiretroviral drugs and choice of baby's feeding options (Shaffer et al., 2000).
Participation increases spousal communication about sexual risk and behavour change (Desgrees-du-Lou et al., 2009a). This becomes especially critical in discordant couples, where men's participation in testing may enable the couple to address condom

use, decrease sex with outside partners and thus help to prevent HIV and other STI transmission to the uninfected partner (Roth et al., 2001; Allen et al., 2003). Studies have also shown an association between men's involvement and contraceptive use (Becker, 1996; Sternberg and Hubley, 2004).

Financial constraints of clients and health facilities have been identified as impacting health services uptake and male participation. A Ugandan study reported that some health workers charged extra beyond the official ANC fees to bridge their own financial gaps while other authors have identified low health providers' salaries as limiting factors for male involvement.

A qualitative study conducted in western Kenya by Reece found that the distance that the male partners have to travel to the clinics for participating in the education, blood tests and 15 counseling, the costs of the transport to the clinics and the amount of time per appointment at the clinic were recognized as barriers to male participation. Access or logistical challenges on the part of men prevented them from participating in antenatal services. Men talked about their perceived principal responsibilities as providers. Thus, time spent at clinics and away from work or other income generating activities was clearly perceived as a barrier to their participation in ANC program Distance, the cost of transport and the clinic operation hours were also mentioned with some frequency (Reece et al., 2010). Data from another study from Uganda showed that majority of participants said that the health facilities were few and located far from the people, making the health services such as counseling and testing faraway. Most of the male partners and men in general chosen the health services to be implemented and extended to their villages or close to their homes in order to save them the costs of time and travel fee.

Byamugisha et al. (2010) reported that harsh, critical language directed at Ugandan women from skilled health experts was a blockade to male participation. Harsh treatment of men by health providers discouraged them from returning or participating in

antenatal activities. Still, some providers did not allow men access to clinic settings. Men cited the negative attitudes of staff members: "Staff members' lack of common courtesy, their "rough handling" of pregnant women and health-care workers not allowing men to enter the antenatal clinic with their partners".

In fact, men experienced healthcare workers who were reluctant to inspire male attendance in antenatal care at all, felt unwelcome and disrespected and thought it was clear that services were designed without taking their particular needs into consideration. The charging of illegal user fees was another barrier cited, the lack of addition of services was stated as discouraging men from getting tested, since they felt they would be "exposed" through special clinics or opening hours (Larsson et al., 2010).

In a study in the DRC, men were asked for voluntary counseling and testing (VCT) in three venues: a bar, a health center or a church. Male participation in VCT was higher in the bar 26.4% and church 20.8% compared to the health center 18.2%. This fallout recommends that more friendly and suitable venues for men are desirable. The lack of space to accommodate male partners in antenatal services was also reported to 16 badly impact male participation. Clinics are often unable to simultaneously accommodate pregnant women and their partners because of a lack of space. Gender specific services to talk exclusively male issues do not exist. Targeted interventions for men, such as custom-made messages, specific health education sessions, and advanced policies to identify male friendly venues would be appreciated for increasing male participation.

Regularly, women have to wait for a long time before receiving antenatal services because of difficult administrative measures which result in poor patient/client through-out the health services. Men, who are in the paid workforce, are often not in a situation to fill nearly the whole day participating in antenatal services.

In a study in Rwanda, it was shown that vital services were often not planned by health workers thus paying to the weak ARV prophylaxis uptake among clients and poor choosing calendars. Health services workers are often shabby worried receiving burn-outs and have to work in a substructure with harshly partial means. In such context, the quality of services is bargained and attractive attention of participating male partners is vigilant an extra load.

Increased male participation in the antenatal series happened in Kinshasa once the antenatal services are open in the evenings between 5:00 – 8:00 pm and at weekends. Most health services offer these services only on weekday mornings, when the majority of men are at work. Yet several studies have acknowledged antenatal services opening hours as a limiting factor for male participation. Physical constraints impact health services interest and male participation. Lack of decentralized services is a reason for low health services uptake and limited male participation.

2.4 Conclusion

Socio-cultural factors; these factors include marital status, education, message, cultural beliefs and customs. The men who are more educated have a high likelihood of attending the antenatal services perhaps because of contact and consciousness. More so, men in lower jobs are less likely to escort their partners for antenatal schedules because they could lose their day's pay as expectant mothers pass so much time in the clinics, others protest of the remoteness of the health capacity which put away a lot of money on transport for two persons. Men are also alleged as dominated by their wives if they escorted them to the clinic. Some women do not want their husbands around as they fear the end of a HIV positive result which would lead to denial and economic deficiency or even domestic violence.

Economic factors; these include financial constraints which may affect male turnout. The men being the breadwinners have hectic calendars. Some of them are on contract or casual jobs, with very inflexible bosses. Nonattendance therefore may mean no pay for that day, or in extreme cases, loss of the job.

The researcher is convinced that this study regardless of its limitations in scope shall fetch out some definite results that will contribute to the actual strategies for enhancing the participation of male partners in antenatal services in Juba Teaching Hospital.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Mouton (2001) defines research methodology as the knowledge of how to do things or the total set of means that scientists employ in reaching their goal of valid knowledge. Research methodology is a systematic way to solve a problem. It is a science of studying how research is to be carried out. Its aim is to give the work plan of research. This chapter deals with the research methodology to the study. It specifically captures the research design, area of study, population of the study, data collection techniques and tools, questionnaires, date quality control, data analysis techniques and ethical consideration respectively (Mouton,2001).

3.1 Research Design

Kumar (1996) defines research design as a procedural plan that is adopted by the researcher to answer questions validly, objectively, accurately and economically. This study was guided by a case study. Researcher Yin defines the case study research method as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (Yin, 2011).

Case study research excels at bringing a researcher to an understanding of a complex issue or object and can extend experience or add strength to what is already known through previous research. Case studies emphasize detailed contextual analysis of a limited number of events or conditions and their relationships. It allowed collection of data to be done under natural setting, and was relatively quicker and cheaper to undertake. Its application allowed for collection of qualitative data from Juba Teaching Hospital by asking individuals about their

perceptions, attitude, behavior or values. The study then described the practices, attitudes, beliefs, challenges and suggestions regarding the male participation in the antenatal services.
The case study is Qualitative research design. Qualitative research is exploratory in nature; it was used to gain an understanding of underlying reasons, opinions, and motivations. The findings of the study were presented through simple statistics, frequency and percentages distributions (Mugendaand Mugenda, 2003).

3.2 Area of the Study

The Juba Teaching Hospital built in 1920s consists of 35 old buildings of bricks and concrete, located in the Centre of Juba. (along Malakia – airport road). The children's hospital is next door. There are presently 560 beds at the hospital. Water supply comes from the town network, but there are boreholes at the premises. The power supply is from the town power supply, but there is a back-up generator. According to Sudan population census contacted in 2008, the population of Juba is about 300000 people.

The Juba Teaching Hospital consists of 192 professional staff: 22 medical doctors, 42 Clinical officers, 100 nurses and 26 midwives. There are both in-patient and out-patient units offering the following services: medical, surgical, pediatric, laboratory, maternity, HCT, HIV/AIDS care and treatment, antenatal clinic, PMTCT and other outreach programmes such as immunization, school health, home improvement and PMTCT follow ups.

It is the only national referral hospital in South Sudan. Juba Teaching Hospital is directly funded by the central government through the National Ministry of Health, and supported by RMF, UN agencies and other NGOs. However, with support from UN agencies and NGOs, the hospital is still not well equipped and lacking basic medical supplies and equipment as well as human resources to deliver quality healthcare services to the people. Therefore, the people at JTH were in position to provide information that was relevant to the study.

3.3 Study Population

Bless, Higson-Smith and Kagee (2006) define population as the entire set of objects or people, which is the focus of the research and about which the researcher wants to determine some characteristics. The population for this study therefore comprised the male partners whose wives have babies or are pregnancy or expecting. Efforts were also made to double check with hospital administration, especially those in reproductive health department (particularly those in charge of ANC and PMTCT services) regarding relevant information about antenatal services in Juba Teaching Hospital. The study also considered CSO/NGO dealing with ANC and maternal services to further gather information so as to established better views of the factors affecting male partner participation in antenatal care services.

3.4 Sampling Procedure

The study used both probability and non-probability sampling method of purposive or judgmental sampling and simple random sampling because the sample selection was based on the nature of the research objectives.

Non-probability sampling implies that the sample was chosen due to its relevance to the study topic rather than their representativeness, which determines way in which people are to be studied and selected. Whereas, the opposite is called probability sampling in which the chances of selecting all the respondents is present

3.4.1 Sample Size

A sample is a small portion of the total set of objects, events or persons that together comprise the subject for the study (De Vos, Fouche, and Delport, 2002) For the purpose of this study a sample size of 55 respondents was proposed but only 50 turned up.

Table 3.1: Shows the Study Population:

Population Category	Sample Seize	Sample Technique	Data Collection Methods
Male partners			
Married with children	10	Simple Random	Questionnaire
Married and expecting	10	Simple Random	Interview
Female partners			
Married with children	10	Simple Random	Questionnaire
Married and expecting	10	Simple Random	Interview
Key informants			
Hospital Administration	10	Purposive	Interview
CSO/NGO dealing with ANC and maternal services official	5	Purposive	Interview
TOTAL	**55 expected respondents**		

3.4.2 Sample Techniques

It refers to the methods by which the researcher selected representative elements from the population.

Purposive Sample Technique

Purposive sampling approach was used to ensure that reasonable representative sample was picked for the study. Purposive sampling generally considers the most common characteristics of the type it was desired to sample, tried to figure out where these individuals could be found and tried to study them (Patton, 2002). Purposive approach was used for hospital administrators and CSO/NGOs dealing with ANC because it is judgmental, good for units or organization. It focuses on particular characteristics of population that are of interest or best to answer the research questions.

Simple Random Technique

Simple random sampling refers to the purest and the most straightforward probability sampling approach. It was selected because it reduced the potential for human bias in the selection. As a result, the simple random sample provided the researcher with a sample that was highly representative of the population being studied (Gravetter and Forzano, 2011). This was suitable for both male and female partners who were selected at Juba Teaching Hospital during the ANC services.

3.5 Data Collection Methods and Instruments

The main methods of data collection were questionnaires and interviews. Both Questionnaires and interview were relevant in this study because they probed respondents' views about low participation in antenatal care and they were found to be an efficient data collection instrument for this study since they facilitated anonymity and probing which also helped participants to express their views freely (Marshall and Rossman, 1995)

3.5.1 Questionnaire

According to Walonick (1993), Questionnaires are one of the most popular methods of conducting scholarly research. They provide a convenient way of gathering information from a target population.

For that matter, questionnaires were used for both male and female partners at Juba teaching Hospital during services.

Some respondents were able to complete questionnaires in their own time while others arranged for a more convenient time. Questionnaires were easy to analyze, and most statistical analysis software can easily process them. They were cost effective when compared to face-to-face interviews.

3.5.2 Interview

According to Moore (2014)Face-to-face interviews have long been the dominant interview technique in the field of qualitative research. In a qualitative interview, the researcher usually develops a guide in advance that he or she then refers to during the interview (or

memorizes in advance of the interview). This approach was used to male/female partners married and expecting and hospital administrators/NGOS dealing with ANC. This was used because it gave more accurate information, example the individual interviewed were able to provide correct information during services time and unclear responses were further probed in an interacting manner.

3.6 Quality Control Methods

For the data to be valid and reliable, the research instrument, in this case the questionnaire and interview, were pre-tested among a sample of 10 selected respondents to check for errors in wording of questionnaire and interview, ambiguity of instructions, and to avoid anything that could obstruct the instrument's ability to gather data in an economical and systematic manner for the attainment of the research objectives. Both questionnaire and interview that were returned were prepared for analysis.

3.7 Data Management and Processing

Data management refers to recorded factual material commonly accepted in the scientific community as necessary to validate research finding: While data processing refers to the process of performing specific operations on a set data, all the completed interview schedules / guides and semi-structured questionnaire were collected, cleaned for validity of information collected, filed and stored for the subsequent management process. It was important because it complied with the University rules and protocol for research integrity. It was also readily available for ongoing use. Final they were applied to que the data collected inform of table using word.

3.8 Data Analysis

Editing referred to a situation where the researcher was in position to check for completeness, accuracy, consistency, word choice, and spelling errors during the interview. Bringing clarity was important otherwise the researcher could draw wrong inferences

from the data. Some respondents made some spelling and grammatical mistakes which the researcher corrected them. The researcher tried as much as possible to avoid biased editing. The researcher was very objective and did not try to hide or remove any information. This was the first step employed during the analysis of data collected.

Coding is the process of organizing and sorting your data. The researcher Codes served as a way to label, compile and organize the data. The researcher was able to summarize and synthesize what was happening in the data. In linking data collection and interpreting the data, coding became the basis for developing the analysis (Gibbs,2007). This processes followed the editing.

The process of placing classified data into tabular form is known as tabulation and this was the third step of analysis employed. A table is a symmetric arrangement of statistical data in rows and columns. Rows are horizontal arrangements whereas columns are vertical arrangements. It may be simple or complex depending upon the type of classification.But the researcher used complex tabulation just to know the population numbers, who are in the majority, male, or female. The complex tables answered the question by giving the column for female and male. Tables also help to reduce the bulky data collected from the field.

3.9. Ethical Considerations

The researcher recognized that the subject of this research was one that directly touched matters associated with gender aspect. This study proposal was subjected to approval of my direct supervisor. The researcher tried to clearly explain to the respondents the purpose, the methodology, the advantages as well as the disadvantages. All attempts were made by the researcher to ensure the anonymity and confidentiality of the data collected were also ensured that data collected were only used for the purpose for which it was collected (academic). Prior to carrying the research, a letter of introduction from Uganda Martyrs University was given to the researcher to carry out the research. That letter was

endorsed by Juba Teaching Hospital which gave the research go ahead for the research.

3.10. Limitations and Delimitations of the Study

The study was limited by financial constraints and the time scale. It was not possible for the researcher to cover all the relevant people in the field, thus the need to formulate a sample which was used to represent the entire area of study.

Scheduling was also affected the researcher since all respondents have other engagements. The researcher found it challenging to make appropriate schedules which were convenient for both himself and his respondents. Here, the researcher had to hire research assistants in order to attend to multiple schedules at the same time.

The study was limited by inadequate finance as it was costly in terms of movement and buying of materials to use. Here, the researcher tried to mobilize for more funds by soliciting funds from sponsors

There was also a problem of some respondent's failure to give out their views and also fill the questionnaires. Here, the researcher supplemented this information by carrying out face to face interviews.

The researcher faced the challenge of language barrier since some respondents speak different languages. Here, the researcher acquired the help of interpreters to enable him communicate effectively with his respondents.

Despite all the above anticipated challenges, the researcher made efforts to adequately address them so as not to compromise the findings of the study in any way, so that the outcome could reflect the majority view of the entire population.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter deals with data presentation, interpretation, and discussion of the research findings from Juba Teaching Hospital in Juba, capital city of South Sudan. This has been presented based on the research objectives which included; antenatal services offered, benefits of attending antenatal services, causes of low participation of male partners and strategies for enhancing the participation of male partners in antenatal services. The researcher presents the views of the respondents after thorough analysis and discussion of the research findings in light of the literature reviewed in chapter two. The methods, instruments of data collection and the nature of data was qualitative, as a result the findings were as well presented, analyzed, interpreted and discussed qualitatively.

This research targeted 55 respondents, but 50 respondents fully participated by completing both questionnaires and interviews. The researcher was unable to get the targeted number because most of the CSO/NGO staff members have been relocated outside Juba due the July 2016 crisis which limited the operation of some organizations. The 50 respondents imply that there was 90.9% response rate. Such response rate was really a significant representative and confirmed to what Mugenda and Mugenda (1999) emphasizes, that a representative rate of 50% is justified for analysis and report.

4.1 Respondent Characteristics

4.1.1 Gender of Respondents

Table 4.2: Showing Gender of Respondents

1.Gender	**NO. of respondents**	**% Respondents**
Male	30	60.0
Female	20	40.0
Total	**50**	**100.0**

The table shows that 60% participants were males compared to 40%for females as far as gender representation is concerned. This implies that the study obtained as much information from the male participants it targeted and it further used the information from the female participants to crosscheck the status of Male participation in ANC services. This was crucial for obtaining objective information for the study.

4.1.2 Age of Respondents

The table below shows age of the respondents of the study and this was helpful to the study explained after the table

Table 4.3Age Group of Respondents

2. Age groups of respondents	**NO. of respondents**	**% of respondents**
20 – 24	**5**	**10.0**
25 – 29	5	**10.0**
30 – 34	**10**	**20.0**
35 – 39	**18**	**36.0**
40 – 44	**12**	**24.0**
Total	**50**	**100.0**

The percentage (36%) indicates majority of respondents involved in the study were 35-39years, followed by the age bracket of 40-44years, and very few were at the age,less than 29 years. This implies that information was obtained from adults who were married and those who were expecting. The age group also means that information was obtained from people who at least have a clue of what is required for someone attending ANC. All the age categories played every significant role in availing the information based on their experiences as far as the age in regards to the factors for low participation of male partners in attending antenatal services. This means the information got from the different age helped in the reliability of the study based on the different experiences associated with age differences.

4.1.3 Education Level of Respondents

Table 4.4: Showing the Education level of Respondents.

3. The education level	**NO of respondents**	**% of respondents**
None	4	**7.5**
Primary	**4**	**7.5**
Secondary	**10**	**20.0**
Tertiary	**32**	**65.00**
Other**00.0**		
Total	**50**	**100.0**

Majority of the respondents (65%) had tertiary level of education, 20% secondary level, whereas both primary and those who did not go to school had 7.5% each. The implication is that education increases rate of participation in antenatal services. Couples (partners) with good education background value the importance of attending antenatal services together with their partners. This is evidenced by 65% of attendance. However, there is still low participation of male partners in attending antenatal services in Juba Teaching Hospital.The Majority of the study respondent's at

least had a formal education experience and this brings the various experiences and understanding of the factors affecting male partner participation in ANC. It further points to the urge of seeking answers to why men who are educated and are thus believe to know the importance of attending ANC as couples would also fail to attend.

4.1.4 Marital Status of Respondents

Table 4.5: Marital Status

4. Marital status	**NO of respondents**	**% of respondents**
Single	**5**	**10.0**
Married	35	**70.0**
Divorced	**5**	**10.0**
Widowed/Separated	5	**10.0**
Total	**50**	**100.0**

Majority Respondents (70%) were married and are believed to participate with their spouses in attending antenatal services. But respondents who were either single, or divorced or separated were only 5%. This means that married people have higher chances of attending antenatal services than unmarried ones. This is justified by a statement from one of the respondents that:

> It makes you have some hope and love him more. The nurses sometimes scream at us and treat us so badly but when your husband is in the delivery room; they won't treat us that way. (Interview with a Female partner on 29/08/2016 at JTH)

4.1.5 Employment Status of Respondents

Table 4.6.: Showing Employment Status

5. Employment status	**NO of respondents**	**% of respondents**
Employed	**35**	**70.0**
Unemployed	**15**	**30.0**
Total	**50**	**100.0**

The table shows that 70% were employed among the participants and 30% not employed. Less than 30% of mothers who came were employed compared to their male partners who are mainly employed with about 70%. The percentage for employed implies that one of the reasons why men do not come to the clinic is because they are busy at their working stations or in their business making ends meet.

This finding is in agreement with what Reece et al.(2010) confirmed in Uganda, in that taxi drivers and "Bodaboda" riders (motorbike taxi riders) were less likely to participate than men followed by other professions such as farmers or construction workers. Reece et al. (2010) also reported that Kenyan men having only an occasional job were less likely to participate in antenatal services. Another study from Rwanda reported that men with a well-paid job were more likely to participate in antenatal services compared to those not well paid. This was further proved with one of the respondents from the civil society and at same time a partner.

> I work for NGO, you have to tell your boss that your wife is pregnant so that by the time she is about to delivered, you are given paternity leave in order to stay with her and the baby at home. Attending antenatal services with wife gives a signal to my working place that in the future, they are going to approve days off. (Interview with a Male partner on 29/08/2016 at JTH)

In addition to the above statement, studies have shown that men who are educated about reproductive health issues and have a job are more likely to support their partners in contraceptive use, use contraception themselves, and demonstrate greater responsibility for their children (Grady et al., 1996). Therefore, creation of secure source of living could contribute greatly to male partner participation in antenatal services.

4.2. The Antenatal Services Offered in Juba Teaching Hospital

This sub section highlights the Antenatal Services offered in Juba Teaching Hospital, but before exploring the services, the factors surrounding the antenatal services have been explored.

4.2.1 Knowledge of Antenatal Services

Table 4.7. Showing Knowledge of Antenatal Services

6. Definition of antenatal services		
	NO of respondents	**% of respondents**
Yes	**30**	**60.0**
No	**20**	**40.0**
Total	**50**	**100.0**

60% respondents had knowledge about antenatal services except 40% who had no knowledge. The respondents (the 60%) were able to outline several antenatal services offered at the JTH and these included: HIV counseling and testing, maternal checkups. The 40% of the respondents tried explain what it meant but could not outline services offered at the antenatal services correctly. Even services like tetanus injections were not quite known to other respondents thus exposing the ignorant of the respondents. This implies that although respondents have knowledge about antenatal services, still there is low participation of male partners in attending antenatal services in Juba Teaching Hospital. This calls for more research of

this nature, to know why there is low participation of male partners in attending antenatal services in Juba Hospital in particular.

4.2.2Antenatal Services offered in Juba Teaching Hospital

The following are the Antenatal (ANC) services offered at Juba Teaching Hospital (JTH)

Table 4.8: Showing Antenatal Services offered at Juba Teaching Hospital

7a. Services offered in ANC in JTH	NO of respondents	% of respondents
Antenatal checkups	**5**	**25.0**
Counseling and guidance	**5**	**25.0**
Antenatal care training	**2**	**10.0**
STD/HIV/AIDS counseling and testing	**8**	**40.0**
Others (specify)	**0**	**00.0**
Total	**20**	**100.0**

HIV/AIDS Counseling and Testing was found to be the most known service (40%). It was established that majority members are aware and do participate in this services as was the case during the interview with one pregnant women at the JTH hospital on the 29/8/2016.

> For me what I know is they always check my blood for HIV/AIDs and thereafter they counsel me...they often encourage us to be there with my husband but I mainly go alone due to his work.

This shows that there is still the need for more sensitization or awareness on the other services offered during antenatal care service provision.

Additionally, it was revealed by the 25% each of the respondents that both Antenatal Checkups and Counseling and Guidance are also provided as some of the antenatal services provided offered by the JTH. This was mainly recorded by those who were receiving the

services and those who had attended ANC previously. This was confirmed in one of the interviews:

> When I came for antenatal checkup, it was realized that I had malaria, which I did not know before the checkup. I had the chance to have early treatment for malaria. (Interview with a Female respondent on 29/08/2016 at JTH)

The findings are in agreement with Family Care Internationals (1997) emphasis that maternal health is a state of complete physical, mental and social well-being of the mother; it is a resource for everyday life of the mother. Maternal health care services comprise of a wide range of health services given to the mother before pregnancy, during pregnancy, labour and after delivery.

The remaining 10% of the respondents selected Antenatal Care Training as the third known services. This means a lot to attain maternal health if all men were aware and engaged in ANC. This would imply that when men are involved in antenatal services, they are well conversant with the services offered, get more information about partners' pregnancy and might return in the next visit to the clinic. However, the question that remains is; why JTH experiences low participation of male partners in attending antenatal services despite efforts being put in place? Thus justifies by statement from one of the respondents:

> My husband has a lot of excuses to say when it comes for accompanying me to attend antennal services. He always tells me that: He is very busy, no time to escort me to the ANC. Since, I do not want to force him to escort me to the ANC, and then I go alone. (Female respondent interviewed on 29/8/2016 at JTH).

This explains the reason why only 10 % of the respondents addressed the issue of antenatal care training during the interview. This implies that although the Ministry of Health is working to increase male participation in attending ANC, men still lack behind s in regarding to other services offered in JTH.

4.3 The Benefits of Antenatal Services in Juba Teaching Hospital

This section discusses the benefits of attending antenatal services; however, factors surrounding benefits such as frequency of attendance have also been discussed.

4.3.1 Importance of Accompanying Partners to Antenatal servicers

The table provides the findings on the importance of Importance of Accompanying Partners to ANC.

Table 4.9. Showing the importance of accompanying partners to Antenatal Services

Importance of accompanying partners to ANC	NO of respondents	% of respondents
Updates about progress of pregnancy	2	10.0
Test for HIV/AIDS	13	65.0
Responsibility/support	4	20.0
Security reasons	1	5.0
Total	**20**	**100.0**

The majority of male partners (65%) emphasized that Test for HIV/AIDS was the most important services for them to accompany their partners. 20% of the male partners also cited Responsibility and support as the second importance for accompany their partners.10% revealed that it updates them on progress of pregnancy. Whereas, 5% accompany their partners for security reasons since Juba city is always volatile. According to the interview, it was found that there is mistrust that prompted the security measure among men to accompany their partners. That is whether women really attend the ANC or not thus prompting men to accompany their partners as exemplified in this case.

> For me, yes, we have to accompany our wives to the hospital. Because there are some women who take money from you that they are going to the hospital but they might not go. But if you go with her, you will be sure that indeed she has been to the hospital. Some can even pick someone's medication prescription on the floor and

> tell you the doctor asked them to buy it just to get money from you... (Interview with one partner on29/8/2016at JTH).

This signifies that there is need for male partners to always accompany their female partners to the clinic. However, it shouldn't be only an accompaniment for the sake of monetary implication but also to ensure that both couple could be checked up for HIV/AIDS/STI and other infections in order to have a better family. This was the case for one of the partners as stated below.

> Since my husband always understands my problems, I talk friendly with him. Sometimes he asks me about something, and we do share our problems as couple. (Interview with Married female partner on 29/08/2016 at JTH)

The findings are consistent with Studies from Pagel et al. (1990), and Mutale et al. (1991), which suggested that male participation in antenatal services results into positive outcome for not only the pregnant woman but also for the unborn child. They concluded that lack of social support; especially from the husbands or family has negative effects on fetal growth. This is what one of the male partners emphasized:

> You see, it will be very good if you are with her. When a woman is going through some difficulty and you are with her, it shows how caring you are. (Interviewed on 29/08/2016 at JTH).

Although several of the findings above show consistency with what Farquhar et, al. (2004) noted, in that male partner support has been shown to be a crucial component in facilitating women's ability to accept preventive interventions, however, there are inconsistencies. For instance, women who disclosed their HIV status to their partners are believed to be more likely to return for post-test counseling, three times more likely to adhere to their ARV prophylaxis/ treatment during pregnancy and at the time of delivery, and five times more likely to adhere to prescribed breastfeeding protocols, accept and modify infant feeding practices and increase condom use in the postpartum period than those who did

not, it is the same reason, that fear of being found positive and consequently get divorce or reprimand may likely influence women to lie to their male partners.

4.3.2 Frequency of Attendance of Antenatal Services by Male Partners

The Table bellows shows how frequent the partners attend antenatal services with their spouses.

Table 4.10: Showing frequency of respondents in attending Antenatal Services

8. How many time have you attended ANC		
	NO of respondents	**% of respondents**
Once	**3**	**15.0**
Every time	**2**	**10.0**
When I am free	**14**	**70.0**
Never	**1**	**5.0**
Total	**20**	**100.0**

Majority (70%) male partners said that they attend antenatal services only when they are free. 15% of men who also attended ANC mentioned that they could attend antenatal services only once. 10% of men strongly said that they attend ANC every time. It was only 5% of men with the lowest percentage who said that they never attended ANC, it was their first time to attend. This justifies the statement from one of the respondents that:

> …men did not come to the clinic because they were too busy in their work places whereas some men worked far from home. (Interview with a Female respondent on 29/08/2016 at JTH)

This justifies that there is low participation of pale partners in attending antenatal services in JTH. This was an indicator that needed government policy and immediate intervention to address the route factors for low participation of male participation in attending antenatal services in JTH in particular.

4.3.3 Benefits of Attending Antenatal Services as Partners

The study also established the benefits the partners accrued as a result of attendance of ANC. The experiences they shared fall under two broad lessons learnt as noted below.

Table 4.11: The gain from attending the Antenatal Services as partners.

11b. What have you gained through attending the ANC as partners	**NO of respondents**	**% of respondents**
ANc is both for men and women	**10**	**50.0**
Regular visit of ANC leads to good health	**10**	**50.0**
Total	**20**	**100.0**

The table shows equal score of 50% for both ANC is both for men and women and regular visit of ANC leads to good health. This implies that both male and female partners had acquired fair knowledge through attending ANC as partners. However, there is need for the Ministry of Health in Juba city to mass awareness on ANC related services like civic education for both male and female partners in order in reduce factors for low participation of male partners in attending antenatal services in JTH in particular.

The findings are in agreement with Nungari(2014) who stated that, it is important to note that both husband and wife as well need to understand and appreciate the discomfort and tiredness that pregnancy may cause to the pregnant woman. The awareness about the demands of pregnancy on the part of the husband and other family members could result into the necessary support the pregnant woman needs from the family members including the husband. The key elements of the birth plan package include recognition of danger signs, a plan for a 9 birth attendant, a plan for the place of delivery, and saving money transport or other costs in case the

need arises. In addition, for birth preparedness, a potential blood donor and decision-maker (in case of emergencies) need to be identified. This is because complications such as hemorrhage are unpredictable and highly fatal if timely treatment is not obtained.

4.3.4 The Environment for Antenatal Care at Juba Teaching Hospital

The place where ANC services are offered contributes greatly to the benefits and participation of partners. This study also established the benefits it offers to the partners.

Table 4.12: Opinion of Respondents on Antenatal Services setting/environment

12. What is your opinion on ANC setting/environment	**NO of respondents**	**% of respondents**
Excellent	**0**	**0.0**
Very good	**3**	**15.0**
Good	**5**	**25.0**
Poor	**12**	**60.0**
Total	**20**	**100.0**

The table shows that majority of 60% of respondents confirmed during interview that ANC setting /environment was poor. 25% said the ANC setting/environment was good, 15 % pointed it was very good whereas no respondents (0.0%) was recorded for those who said it was excellent. This implies that the setting/environment of ANC in JTH is lacking the desirable conditions set up for a good ANC. The ANC in JTH has fallen short of standard. Perhaps, this answers the question why there is low participation of male partners in attending antenatal services in JTH. This is justified by a statement from one of the respondents that:

> Sometimes if the man accompanies you to the hospital, the nurses can utter some words that won't encourage him to go with you the next time you ask him to. (Interview with a Female partner on 29/08/2016 at JTH)

4.4. The Causes of low Participation of Male Partners in Antenatal Services

In order to effectively capture the causes, the study first explored the status of accompaniment of female partners by their male counterparts. Later the various causes have been discussed.

Table 4.13.: Showing the Status of Accompanying Female Partners by male partners for Antenatal care.

13a. Do you often accompany your partner to ANC		
	NO of respondents	**% of respondents**
Yes	**7**	**35.0**
No	**13**	**65.0**
Total	**20**	**100.0**

The majority (65%) male partners said they did not accompany their female partners to the clinic. Only 35% of men who accompany their female partners to the clinic. This means that most men are uncomfortable with pregnant women and are shy so they did not want to be a round woman. This was evidenced by statement from women during interview that, "men often complain of so much of the femininity in the clinic like so many women are always crowded in clinic".

During the interview, the respondents outlined the following as the causes of low participation of male partners in antenatal services:

> The problems at the hospital are enormous. The nurses are not friendly at all. Some of the words they utter are too ugly. What is too humiliating is where you do not have any money at all. They will tell you, this place is for staffs so do not pass there, this place is for pregnant women, and you are not supposed to pass there. (Interview with a Male partner on 29/08/2016 at JTH)

The findings are in agreement with Byamugisha et al. (2010) and Larsson et al. (2010) who reported that harsh and critical language directed at Ugandan women from skilled health experts was a

blockade to male participation. Harsh treatment of men by health providers discouraged them from returning or participating in antenatal activities. Still, some providers did not allow men access to clinic settings. Men cited the negative attitudes of staff members: "Staff members' lack of common courtesy, their "rough handling" of pregnant women and health-care workers not allowing men to enter the antenatal clinic with their partners".

In fact, men experienced healthcare workers who were reluctant to inspire male attendance in antenatal care at all, felt unwelcome and disrespected and thought it was clear that services were designed without taking their particular needs into consideration. The charging of illegal user fees was another barrier cited, the lack of addition of services was stated as discouraging men from getting tested, since they felt they would be "exposed" through special clinics or opening hours. This was further alluded by one of the respondents below:

> The clinic does not keep time. Time management is poor. If you are asked to come at 9:00 am, you find some nurses are not yet in. You have to spend another one to two hours for them to come. This doesn't help us with our work schedules. (Interview with Male partners on 29/8/2016at JTH)

The findings are in agreement with Reece et al. (2010) who provided that time spent at clinics and away from work or other income generating activities was clearly perceived as a barrier to their participation in ANC program. Distance, the cost of transport and the clinic operation hours were also mentioned with some frequency. Data from another study from Uganda showed that majority of participants said that the health facilities were few and located far from the people, making the health services such as counseling and testing faraway. This was further shown during the interviews:

> For me, I like to be there but the doctors will not allow me to go inside. According to the doctors, the hospital has a lot of women in labour so I cannot be allowed to enter. I heard, in abroad if your wife is in labour, you can go and stand beside her and be

encouraging her to push but here it is not like that. (Interview with a Male partneron29/8/2016at JTH)

The findings are inconsistent with Larsson et al. (2010) findings which states that, in fact, men experienced healthcare workers who were reluctant to inspire male attendance in antenatal care at all, felt unwelcome and disrespected and thought it was clear that services were designed without taking their particular needs into consideration. The charging of illegal user fees was another barrier cited, the lack of addition of services was stated as discouraging men from getting tested, since they felt they would be "exposed" through special clinics or opening hours.

4.4.2 Time Availability to attend Antenatal services as Partners

Table 4.14: Time availability to Attend Antenatal Services as Partners

13b. Time availability	**NO of respondents**	**% of respondents**
Yes: They have time	**7**	**35.0**
No : They do not have free time	**13**	**65.0**
Total	**20**	**100.0**

This table shows that 65% of respondents said during interview that they did not have free time to attend ANc but respondents with 35% said yes they could attend ANC because they were government employees; they had privilege to use government vehicles. It implies that men who are low income earners hardly acompany their partners to ANC thus leading to low participation of male partners in attending antenatal services in JTH. This can be justified by a statement from one of the respondents:

Some us come from a far distance, if you are coming with your wife to the clinic it is very expensive, because you have to pay for two persons to and from. (Interview with a Male partneron29/2016at JTH)

4.4.3 Observance of Appointments to attend Antenatal Services by Partners

After attending the first ANC, there are also other scheduled dates for a continuous ANC services. It is thus expected that the partners oblige to the time allocated and actively follow them. This study also established this aspect and how it relates to causes of low participation

Table 4.15: Observance of the periods recommended and follow them in attending Antenatal Services as partners

14a. Do you observe the periods recommended and follow them in attending ANC as partners		
	NO of respondents	**% of respondents**
Always	**2**	**10.0**
No (Not at all)	**12**	**60.0**
Sometimes (miss sometimes)	**6**	**30.0**
Total	**20**	**100.0**

Majority of 60% confirmed during interview that they did not observe the periods recommended and follow them in attending ANC as partners. 30% of respondents pointed out that they sometime or miss sometimes to observe the periods recommended and follow in attending ANC as partners. Only 10% testified that they always observe the periods in attending ANC as partners. This implies that most couples in Juba city did not know follow the recommended period about ANC and dominant reason behind this fluctuation is the fear for loss of time for making ends needs. They believed that they would have made money other than go 'waste'time on women issues. Such practices are common as proved by the statistics above. Therefore, the government needs to urgently increase their level of awareness that every citizen takes the campaign with seriousness it deserves. More reasons for not following the allocated time are presented in the table below.

Table 4.16: Reasons for Missing Appointments

14b. Explain the reasons for missing appointments		
	NO of respondents	**% of respondents**
They use government vehicles	**2**	**10.0**
Have no free time at all	**12**	**60.0**
Only during weekends	**6**	**30.0**
Total	**20**	**100.0**

This table shows that majority of respondents 60% have no time at all to follow the recommended periods of attending ANC as partners. 30% of respondents said that they only attend ANC as partners during weekend and 10% use government vehicles to facilitate their movement to ANC as partners. This implies that ASNC clinics are not equally distributed within the capital city of Juba except JTH being the only referring Hospital in the city and for the Country at large make very expensive for partners to access the ANC services. Thus that leads to low participation of male partners in attending antenatal services in JTH.

4.4.5 Factors Limiting Men Attendance of Antenatal services with their expecting Spouses.

Table 4.17: The factors in attending Antenatal Services Limiting men to accompany their partners

15. What do you think are the factors in attending ANC that would make men not to accompany their partners		
	NO of respondents	**% respondents**
Fear of HIV/AID result (-ve)	**2**	**10.0**
Financial constraints	**3**	**15.0**
Cultural beliefs (woman's duty)	**14**	**70.0**
Not answered**1**		**5.0**
Total	**20**	**100.0**

The table shows that the majority (70%) of respondents who revealed that ANC was a woman's duty (cultural beliefs). 15% of respondents mentioned that financial constraints as a factor that make some men

not to accompany their partners to ANC services in JTH. This implies that there is inadequate knowledge about antenatal services among men. They view ANC as not their responsibilities. This exactly answers the question why there is low participation of male partners in attending antenatal services in JTH.

4.5 The strategies for Enhancing Participation of Male Partners in Antenatal Services

Table 4.18: Showing the strategies for Enhancing Participation of Male Partners at Antenatal Services.

16. Measures to ensure male partners continuously attend antenatal services	**NO of respondents**	**% of respondents**
Health workers expected to be friendly	**3**	**15.0**
Adequate space and chairs be provided	**3**	**15.0**
Time spent be reduced for male partners	1**3**	**65.0**
Civic education be encouraged by authorities	**1**	**5.0**
Total	**20**	**100.0**

The majority (65%) of male partners suggested that time spent in the clinic be reduced. 15% of men had the view that health worker should be friendly and there should be also adequate space and chairs in the clinic to cater for both male and female partners. It was only 5% of men who suggested, government should introduce civic education in order to enhance causes for low participation of male partners in ANC.

This implies that men who went with their spouses to antenatal did so because the health staff requested them to do so, otherwise they wouldn’t have gone.

According to the findings, the following were highlighted the followingstrategies should to help reduce the factors for low participation of male partners in attending antenatal services in Juba Teaching Hospital. Health Workers are expected to be friendly, adequate space and enough chairs be provided, time spent be reduced or male partners and civic education be encouraged by authorities.

The findings are related with what Kululanga, et al. (2011) and Mullany(2006) advocated for. That is mass education, large group counseling, peer education and modification in the service delivery to include incentives for male involvement from the literature, there is evidence that the level of male involvement varies from one community to the other and the socio-cultural and service delivery systems factors that affect them also vary. It is important to determine from each community, the factors that are significant. Research that focus on women; indirectly confirm the notion that pregnancy and its related activities are largely feminine issues. There is the need for research such as this one that focuses on men to get their perspective on antenatal services. As most interviewees advanced "Staff (health workers) should have a friendlier attitude towards male partners when they attend clinic".

Mullick et al, (2005) further build on this argument in that, short waiting time at the health facility is predictive of increased male accompanying the wife for antenatal services. The findings of this study are in agreement with findings from several studies that have reported long waiting time at the health facility as being one of the reasons for low participation of male partners in attending antenatal services.

It is possible that if waiting time at the health facility were reduced it will result in increased male accompanying the wife for antenatal services. This is because many men have long working hours and long waiting time makes it difficult to find time off to attend maternal health services. The implication of the finding is that we need to increase on the number of midwives in the health facilities if we are to achieve the waiting time at the health facilities of less than one hour when women are attending antenatal services at Juba Teaching Hospital. This was true in this case:

> Educational campaigns should be carried out in the community to sensitize men on the need to get involved in

> maternity care. (Interview with a Male partner on 29/8/2016 at JTH)

Mullick et al, (2000) and Ruhweza et al.(2009) also build on what the partner has advanced. Where demand for money by some health workers before rendering services and lack of drugs and supplies in the government health facilities, are the reasons given by men for not escorting the wife during labour. Reported similar findings of household paying for health care in Jinja district. The same study also reported that health workers told their clients who came for care in the government health facilities that there were no drugs at the health facility but on making payment, drugs suddenly became available. Poverty could be a major bottleneck to men accompanying their partner for fear of being embarrassed in case they fail to pay the health workers or not being able to pay for supplies like gloves that the health workers demand during delivery. Such scenario is termed corruption. There is need government should put in place measures to take the culprits into book.

> One day I was denied access to ANC room with my wife just because I am a man. Male partner during interview on 29/8/2016 at JTH)

Poor attitude of health workers and fear of being harassed by health workers are some of the reasons contributing to low male involvement. This finding is consistent with other studies in Kenya where poor behavior of service providers has been found to adversely affect male partner's capacity to use reproductive health services. This is probably because men fear being the subject of verbal and emotional, sometimes physical abuse and this prevent men from being involved. Such cases should be reported to police and reported on various media so that on one repeats that any more (Alka et al, 2005).

According to this study, the fact that health workers don't allow men entry into the delivery room may be responsible for some men not accompanying their partners for maternal health care. Similar findings were reported in the study carried out in South Africa. In

South Africa, some men indicated that even when men accompanied their partners to the clinic, they generally waited from outside. These finding imply that much as we are advocating for increased male involvement in maternal health, the health system has not yet been prepared to accommodate men who escort the women during labour. Therefore, the government has to introduce policy whereby men are free to enter ANC room with their female partners. If men and women see their nakedness at home what is wrong with the same men seeing their wives' nakedness at ANC?

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary of findings in line with the study objectives. The researchers also made conclusions, recommendations and suggestions for further research. These were based on the study purpose of establishing the factors for low participation of male partners in attending antenatal services in Juba teaching Hospital.

5.1 Summary of the Findings

The first research question sought to answer the question what are the antenatal services are offered by Juba Teaching hospital and the study established the following services that JTH offers to pregnant women and their husband; HIV/Aids testing and counseling, Antenatal care training, Antenatal checkup etc.It was found that these services are crucial for the wellbeing of the family that is the pregnant mothers and their babies.

The second research question focused on addressing the benefits of attending antenatal services at JTH. The benefits of join attendance of ANC are great and can reduce health complications and these included; high blood pressure, preterm labor, a loss of pregnancy or miscarriage, anemia and sexually transmitted diseases including HIV. All these pregnancy complications are manageable through attending antenatal services jointly by both female and male partners.

The third objective established the causes of low male partner participation in antenatal services in Juba Teaching hospital and these cause are varied ranging from socio cultural issues to economic reasons. The caused found are that some men believe that

attending antenatal services is only for women. It is a taboo to for a man to attend ANC with his female partner. Whereas some men say that attending ANC together with their female partners is cost on men. You have to pay transport for two persons to and from. Other men say that they do not have time to accompany their wives to ANc because they are busy with work schedules.

The fourth objective sought to measures to address low male partner participation in ANC services and it established the following strategies to help reduce the factors for low participation of male partners in attending antenatal services: Health Workers should learn to be friendly, they have to behave professional and with dignity a human deserves. Adequate space and enough chairs should be provided, time spent be reduced or male partners and civic education be encouraged by authorities in order to encourage attendance of male partners.

5.2 Conclusion

The research findings revealed that Men who attended antenatal services with their partners did not have a significantly higher level of knowledge on antenatal services offered such as pre-eclampsia, tetanus toxoid immunization and intermittent preventive treatment for malaria during pregnancy etc. which was the major factor for low participation of male partners in attending antenatal services in Juba Teaching Hospital. Male partner participation in antenatal services is influenced by varied factors which may relate to the man’s socio-economic surrounding such as financial constraint and social cultural believes and practice for example, men are not supposed to follow their women to the ANC.

Men should keep off from the belief that reproductive care is only a woman’s care. There is need for concerted effort from all stakeholders if success will be achieved in improving male participation in the antenatal services in Juba County. Ultimately,

this should result in improved antenatal services and reduced maternal mortality and accelerate the achievement of the SDGS.

5.3 Recommendations:

The Mayor of Juba City together with the Ministry of Health should take steps to raise awareness on the importance and benefits of male participation in antenatal services to both male and female partners. This could be achieved through the issuing of invitation letters for men to attend antenatal services with their partners, designing messages that specifically target men who accompany their spouses for antenatal services and the involvement of the village health teams and community leaders in reaching out to men and encouraging their participation in antenatal services in Juba teaching Hospital.

To increase male participation in antenatal services, the JTH health managers together with the Ministry of Health have to ensure the availability of medicines as supplies at the health facilities, improve the health workers' attitude towards men who accompany their partners for maternal health care services and stop illegal charges for services by health workers. Once male participation in antenatal services is improved at Juba Teaching Hospital, this will lead to improved health status of parents and their babies.

The ministry of Education with partnership with Ministry of Health should make sure both girls and boys in school be encouraged to stay in school beyond the primary level for sustainability of increased male participation in antenatal services.

A study to establish factors that motivate male participation in antenatal services would further strengthen strategies for improving male participation in antenatal services.

5.4 Suggestion for further Research:

A study to assess the male-friendliness of the health facilities providing antenatal services in the country focusing on the infrastructure, timing of services and staff attitudes. The challenges faced by care providers and the health facilities in providing male-friendly antenatal services should also be explored.

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APPENDICES

APPENDIX I: Questionnaires for selected respondents

Dear Respondent

My name is Ndikiri Simon, a student of Uganda Martyrs University with registration number: 2012 B103 10032. Am conducting a study on "Exploring the factors for low participation of male partners in attending antenatal services in Juba Teaching Hospital, in South Sudan". It is carried as a partial fulfillment of the requirements for the award of a Bachelor of Democracy and Development Studies of Uganda Martyrs University Uganda. Your contribution, opinions and experience will be highly appreciated. All the information collected shall be kept confidential and used for academic purpose.

Thanks for your cooperation.

Section A: Background information

1. Gender
   i.Male[ ]
   ii.Female [ ]

2. Age in years……. [ ]

3. The highest academic level
   i.None [ ]
   ii.Primary [ ]
   iii.Secondary [ ]
   iv.Tertiary [ ]
   v.Others [ ]

4. Marital status
   i.Single [ ]
   ii.Married [ ]
   iii.Divorced [ ]
   v.Widowed/separated [ ]

5. Employment status
   i.Employed [ ]
   iiUnemployed [ ]

6. Number of children in the household
   More than 4 children [ ]
   Less than 4 children [ ]

Section B: The antenatal services in Juba Teaching Hospital

7a) Do you know what is meant by antenatal services care?

Yes [ ]

No [ ]

8a). Do you know about antenatal care?

Yes [ ]

No [ ]

8b). what services do you know are offered in ANC in this hospital?

a) Antenatal checups

b) Counseling and guidance

c) Antenatal care training

d) STD/HIV/AIDS counseling and testing

e) Others (please specify) ……..

9. How many times have you attended antenatal clinic?

i. Once [ ]

Ii. Every time [ ]

iii. When am free [ ]

iv Never [ ]

Section C: The benefits of antenatal services in Juba Teaching Hospital

10. Do you think is the importance of accompanying your partner to the ANC?

Yes [ ]

No [ ]

b). If yes, why do u think it's important?

……

……

……

11a) How often or how many times have you attended clinic as partners?

i. Once [ ]

ii. Every time [ ]

iii. When am free[ ]

v. Never [ ]

11b)What have you gained through attending the ANC as partners?

……

……

12) What is your opinion on the antenatal clinic setting/environment?

Excellent [ ]

Very good [ ]

Good [ ]

Poor [ ]

Section D: The causes of low participation of male partners in antenatal services in Juba Teaching Hospital.

13a) Do you often go as partners or accompany your partner to ANC?

Yes [ ]

No [ ]

b) State the reason for your answer above.

……

……

14a) Do you observe the periods recommended andfollow them in attending antenatal clinic as partners?

a) Always (I never miss)

b) No (not at all)

C) Sometimes (miss sometimes**)**

14b) please explain the reasons for your choice of answer above.

……

……

14. What do you think are the factors in the antenatal clinic that would make men not to accompany their partners?

……

……

Section E: Strategies for enhancing the participation of male partners in antenatal services in juba Teaching Hospital

16. In your opinion, what measures need to be taken to ensure male partner continuously attend antenatal services?

……

……

……

17. Give suggestions on how to make the clinic environment more conducive and welcoming to the men.

……

……

……

APPENDIX II Interview Guide

Date: ……..

Venue: ……..

Occupation/Position: ……

1. Do you know about antenatal care? If yes, what is it?
2. Have you ever attended antenatal services? If yes/No, why did/didn't you attend?
3. What services do know that are offered in the antenatal clinic?
4. Do you think is importance of accompanying your partner to the ANC? If yes, why do you think it's important?
5. What is your opinion on the antenatal clinic setting/environment?
6. What do you think are the factors for low participation ofmale partners in antenatal services in Juba Teaching Hospital?
7. What are your suggestions on the strategies for enhancing the participation of male partners in attending antenatal services in Juba Teaching Hospital?

APPENDIX III: Proposed budget for proposal and report writing

ITEM	**QUANTITY**	**RATE**	**TOTAL COST**
Stationery items			53,000/=
Transport	-	-	570,000/=
Research Assistants	6	20,000/=	120,000/=
Dissertation typing, printing and binding	4	40,000/=	160,000/=
Miscellaneous	-	50,000/=	50,000/=
TOTAL			**953,000/=**

APPENDIX IV: Time Frame/Work plan

TIME FRAME FOR RESEARCH REPORT	
DURATION	**ACTIVITY**
January - February 2016	Concept note submission Meeting with the supervisor
March – April 2016	Proposal writing
June – July 2016	Approval of proposal and data collection
September – October 2016	Report writing and discussion with supervisor
November 2016	Submission of three copies of spiral bound dissertation for marking

APPENDIX IV: Introduction Letter

Uganda Martyrs University

making a difference

Department of Development Studies
School of Arts and Social Sciences
Email: ieds@umu.ac.ug

Your ref:
Our ref: dds : field introduction letter 15-16

Nkozi, 25th, August, 2016

Dear Sir/Madam,

Re: Letter of Introduction

This is to introduce to you **NDIKIRI Simon** Reg. No. **2012-B103-10032** who is an undergraduate student in the Department of Development Studies at Uganda Martyrs University - Nkozi. He is required to carry out research on a topic:

"Exploring the Factors for Low Participation of Male Partners in Attending Antenatal Services in Juba Teaching Hospital- South Sudan."

This is as a requirement for the award of Bachelor of Arts in Democracy and Development Studies.

I would like to request you to render him assistance in collecting the necessary data for writing his Dissertation.

MINISTRY OF HEALTH (R...
29 AUG ...
...TH
JUBA TEACHING HOSPITAL
ANC
29/8/2016

Thank you in advance for your assistance.

Yours Sincerely,

Dr. LUSWATA Albert
Head of Department

UGANDA MARTYRS UNIVERSITY
Dept. of Development Studies
School of Arts and Social Sciences