ACTIVE MALE PARTNER PARTICIPATION IN MATERNAL HEALTH CARE SERVICES

CASE STUDY: HEALTH FACILITIES IN LIRA DISTRICT

A POSTGRADUATE DISSERTATION PRESENTED TO FACULTY OF HEALTH SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN PUBLIC HEALTH IN HEALTH PROMOTION

UGANDA MARTYRS' UNIVERSITY

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2015-M282-20021

MAY, 2018

DEDICATION

I dedicate this report to every person who made this achievement a reality, especially to my supervisor Dr. Miisa Nanyingi and the entire teaching and non-teaching staffs of Uganda Martyrs' University (UMU), Nkozi I can't thank you enough, just know I am so very much delighted and dearly appreciate all your tireless efforts and support cheers to the entire team. May the Grace of our Father God in Heaven bless you abundantly? Amen

ACKNOWLEDGMENT

First, all the glory and thanksgiving go to God the Almighty for this gift and blessed day.

I wish to express my deep gratitude to all the members of the dissertation committee for their invaluable support and guidance, and the tremendous amount of time spent on supporting and guiding me to complete this dissertation.

I thank the entire faculty of Health Sciences and special thanks to Dr. Miisa Nanyingi for her tireless support and endeavour as my supervisor to have this study concluded.

A sincere thanks to the District Health Officer (DHO) of Lira district, Dr.Ocen Pbuchan, for all your support and guidance, you opened the door and made it easy for me, thank you a lot Doc.

I wish to thank the health workers in all their respective capacities for their cooperation, guidance, and actively participating in the study.

Thanks to all other participants in their various capacities for accepting to be respondents in this study willingly and for giving the information that was relevant to the objectives and questions of this study.

I am also deeply indebted to my parents (both Dad and Mum), whose love served as a foundation to instil in me the value of life-long education and quest for knowledge in this long journey.

I profoundly thank my wife and children, my brothers and sisters and friends for the support in one way or another, know that you are all highly appreciated.

I thank all other authors of various published journals, articles, books, among others that enabled me to enrich this study I thank you, your works were all amazing and made a lot of sense to my study objectives and questions.

To all those who supported me indirectly, thank you all know that I appreciate you a lot.

In summary, all persons who supported me in this study just know I dearly appreciate and was humbled by your contributions and support towards this common goal.

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ABBREVIATIONS AND ACRONYMS

AIDs	Acquired Immunodeficiency syndrome
ANC	Antenatal Care/Clinic
AMMP	Active Male partner Participation
EMTCT	Elimination of Mother to Child Transmission of HIV/AIDS
FP	Family Planning
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
ICPD	International Conference on Population and Development
IPT	Intermittent Preventive Treatment for malaria during pregnancy
MDGs	Millennium Development Goals
MI//P	Male Involvement/Participation
MMR	Maternal Mortality Rate
MoH	Ministry of Health
NGO	Non-Government Organization
PMTCT	Prevention of Mother-to-Child Transmission of HIVAIDS
RH	Reproductive Health
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
UBOS	Uganda Bureau of Statistics
UNICEF	United Nations International Children Emergency Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

DEFINITION OF KEY TERMS

Active Male Partner Participation

UNAIDS, (2016) defined active male partner participation starts with male involvement as entry point to AMPP; to include active participatory decision making, shared responsibilities ("win-win scenarios"), generation of ideas, leading to reduced domestic chores (United nation, 2016 or UNFPA, 2005).

Skilled Antenatal Care (ANC)

Matongo, et al, (2014) define skilled antenatal care as the clinical assessment of a mother and foetus during pregnancy and health education, for the purpose of obtaining the best possible outcome for the mother and child. The components of ANC services include: risk identification; prevention and management of pregnancy-related or concurrent complications or diseases, health education and health promotion.

Skilled maternal care services

The study focused on skilled maternal health care services in antenatal clinic; delivery clinic and postnatal clinic

ABSTRACT

Introduction/Background: Globally, AMPP is considered a crucial component in the optimization of holistic better family and community health care outcomes lies on recognizing important roles played by male partners, as they are considered sole decision makers, as agents of positive change, Walston and USAID, (2005) (UNFPA, 1995; United Nations, 1996). To mitigate or eliminate or reduce the 3 sources of delays (delay in seeking H/C services, delay in arriving and delays in receiving appropriate H/C services. This study was conducted to find out the different factors influencing the nature and level of male partner's actively participating in skilled maternal health care services in Lira district.

Methodology: This study was a cross-sectional descriptive survey that employed both (quantitative and qualitative methods of data collection and analysis). It was a health facility based and data was collected from selected health facilities in Lira District, Northern Uganda. A total of select 358 respondents were interviewed of the 422 sample study population. KIs and FGDs was used to collect qualitative data which was analysed according to themes while quantitative data were analysed using statistical package for social science (SPSS) version 20.

Findings (major only): Nature: 57% of the 208 escorted their spouses for maternal care services and 25% tested for HIV, hence Male involvement not AMPP. Found a significant mean difference and a significant relationship between men's income status and nature of their AMPP at ($F>7.98$) and a ($P<0.001$), age brackets and nature of AMPP ($P<0.012$); between men's levels of education and their nature of AMPP at a ($F>6.89$) and a ($P<0.014$); employment status and nature of MPP at a ($F>4.5$) and ($P<0.000$); between residence type and nature AMPP a ($F>8.2$) and a ($P<0.003$). Religious affiliation groups (Catholic, protestant, Muslim and others) was not to have significant influence on nature of AMPP at ($F<1.05$) and a ($P>0.270$).

Level: The finding of the study revealed that the level of AMPP in skilled maternal health care services is low in Lira district at 19.8%; with 80.2% of the participants reported not ever attended, Not given FS, Not participated in decision making in skilled MNCH, SRHS with their partners. (Agreed to by Nkuoh, et al. 2010 and Nantamu, 2011 that AMPP falls between 5 to 25%). The study found men's income status, age, level of education, employment status, and residence type to influence level of AMPP in MNCH to have significant influences on the levels of AMPP. However, no significant influence and on mean difference was found between religious affiliation groups and level of AMPP at ($F<1.05$) and a ($P>0.270$).

Factors influencing the observed nature and level: The major influencing factors as told by the male partners were: - Men left un attended to by nurses (16%); men's fear to test for HIV (15%); men's claim to have busy schedules as bread earners (15%) and a lot of time is wasted/spent at MNCH clinics (14%), nurses don't men (12%), H/F are far (6.7%), No invitation letter for men (4%) and least messages passed focused on women (3%). (Larsson et al. 2010; Musheke, Bond and Merten (2013); Nkuoh et al. 2010).

Policy implications & Recommendations: National level: Amendment of the national strategy policy guideline for men involvement to include AMPP; disseminate policy to districts and implementing organisations. **Health promotion:** Re-design and re-orient MNCH, SRHS health care services; **Lira district:** Strengthen collaborations/partnerships using participatory approach to project programming; increasing public-private partnerships;

Conclusions: The study recognized the important roles male partners play in supporting women in accessing skilled MNCH services and therefore, there's need to review, re-design and re-strategize new policies and strategies to increase AMPP in skilled MNCH services.

Areas of further studies: The study suggested that further studies be undertaken to assess of the effectiveness of NGO strategies in enhancing male partner's active participation in skilled MNCH, SRHS and in other gender programmes; assess of the appropriateness of maternal child health care services given to expectant mothers who arrive late and assess of the appropriateness of maternal child health care clinics on maternal and child morbidity and mortality.

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Introduction

Globally, active male partner participation (AMPP) is considered a crucial component in the optimization of holistic better family and community health care outcomes lies on recognizing important roles played by male partners, as they are considered sole decision makers and agents of positive change, Walston and USAID, (2005) that should mitigate or eliminate or reduce the 3 sources of delays (delay in seeking health care services, delay in arriving and delays in receiving appropriate health care services which is considered a contributor to the high morbidity and mortality of mothers and children of <5 years (UDHS, 2016. 336/100,000 live births) (UNFPA, 1995; United Nations, 1996) and a lot of campaigns have built over time to this effect,

However, even with the increased campaigns to promote and implement AMPP, men are rarely present during their spouse's clinic days, most men attributing their behaviour to being left out of MNCH, SRHS and from other gender programmes, though men claim some willingness to actively participate Dharma, (2013). Nkuoh et al. (2010) estimated to be between 5 to 25% and agrees with Falnes et al. (2011) and Larsson et al. (2010) findings.

Therefore, it is against this background that, this study was conducted to find out the different factors influencing the nature and level of male partner's active participation in MNCH.

1.1 Background of the study

Active Male partner participation is a crucial component in the optimization of skilled antenatal care, delivery and postnatal services. Today is more than 20 years after the 1994 Cairo international Conference on Population and Development programme of Action (ICPD) and the Fourth World Conference on Women, Beijing 1995 where it was observed that "male responsibilities and participation" in sexual and reproductive health are critical for

the health of the family and community, great achievement in active male partner participation is yet to be realized.

Although the ICPD emphasized men as agents of positive change the fundamental role men play in supporting women's reproductive health and in transforming the social roles that constrain reproductive health and rights, the effort of different national government and communities need to be documented for critical appraisals.

It was during this Cairo ICPD, where all governments were called upon to put special efforts in emphasizing men's shared responsibility and the promotion of their active participation in responsible parenthood, sexual and reproductive behaviours, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes was made(UNFPA, 1995; United Nations, 1996).

Dunlap, et al. (2014); Aizire, et al.(2013); Gourlay, et al.(2013); Wetstein, et al.(2012); and WHO, (2011) observe that active male partner participation in skilled antenatal care services and in other maternal child health and sexual and reproductive health services is considered as one of the missing factors in the overall implementation of the maternal child health, sexual and reproductive health programmes of any kind.

This was confirmed by Walstonand USAID (2005) who found out that, most health or gender programmes lack clarity as to how active male partner participation should be promoted and thus implement their services with the unspoken assumption that services are equally accessible to both sexes.

UNAIDS, (2016) defined active male partner participation as an inclusive processes that extends beyond just physical involvement of men to men being actually actively engaged (evidenced-based) by the health workers in all health related discussions, generation of ideas, decision making and taking on different roles of "shared responsibilities".

Walston and USAID, (2005) observed that, men traditionally are the decision makers in families in Sub Saharan Africa (SSA),but according to Dharma, (2013) most men in patriarchal societies of developing countries in SSA feel left out or missing in antenatal healthcare programs.

Nkuoh, et al, (2010); Trinh, (2006); and Adekanle, (2008) observe that active Male partner participation in Antenatal care services has remained low in SSA. While ManjateCuco, (2016) reaffirmed Nkuoh's et al., (2010) and restated that men are rarely present in Antenatal care/PMTCT programs in spite of its associated positive outcomes for maternal and child health. This implies that active male partner participation continues to be low in SSA as observed by Kariuki and Seruwagi, (2016).

Nkuoh et al. (2010) observed that male partner participation is estimated to be between 5 to 25% and their findings were consistent with the findings of the studies carried out byFalnes et al. (2011) and Larsson et al. (2010).

Most women complain of their partner's unsupportiveness in skilled antenatal care and other reproductive health services as observed in Wachira, et.al. (2012); Nkuoh, et al. (2010); Falnes, et al. (2011); Larsson, et al, (2010); and Nompumelelo, et al. (2017) noticed that adherence to medical guidelines/standards is still a challenge to most women in patriarchal societies such as Uganda. Women emphasize the role male partner plays in modifying the behavioursof women when seeking professional health care (Mburu, et.al. 2012).

Uganda government led by the ministry of health (MoH) recognized the importance of active male partner participation in skilled antenatal care and in other reproductive and maternal health care programs as emphasized during the Cairo ICPD and the Uganda government spearheaded by ministry of health (MoH) developed a National strategy policy and guidelines for enhancing active male partner participation for all health programming.

Despite this effort, male partner participation in skilled ANC is still estimated to be low ranging between 5to 25% (Nkuoh, et al. 2010).

The policy takes special care to include all men with spouses in all family centred health programs:- such as in sexual and reproductive health care services (SRH), like skilled ANC and in other maternal and child health care services; nutrition; water and sanitation; family planning; immunizations; and the fight against malaria and HIV/AIDS (MoH, Uganda, 2014). Therefore, at health facility levels or hospital setting in SSA, the levels of male partner participation according to Ditekemena, et al. (2011) also vary between twelve point five (12.5%) percent and eighteen point seven (18.7%) percent and concluded that only a few male partners have been found to be in contact in ANC services and in other maternal and sexual and reproductive health services.

Reports for Lira district for the five consecutive years beginning from 2012 to 2016 shows that at every skilled Antenatal care visits, men accompany their spouses only on their first skilled ANC visit. The habit to accompany their spouses to ANC visits is seen to drastically decline throughout the subsequent skilled ANC visits (2^{nd}, 3^{rd} and 4^{th} visits) with very few or no male partner accompanying his spouse in the 2^{nd}, 3^{rd}, and 4^{th} visits. Monthly reports show that out of estimated 20-30 expectant mothers at each ANC visit, less than 6% are accompanied by their spouses as recommended in the guidelines for oriented-focused skilled ANC visits. (DHIS2 105, 2010 to 2017)

As evidenced by the findings observed in a 2010 study conducted by Nkuoh, et al, that among 388 men whose expectant spouses were attending antenatal care at Mbale Regional Referral Hospital in Eastern-Uganda and only 5% of these men accompanied their spouses to the antenatal clinic. However, little has been achieved so far to have all male partners of expectant spouses/mothers actively participate in skilled ANC and it is twenty three (23) years after Cairo ICPD conference and that it is estimated that only between 5 to 25% of men are actively involved and participate but some related studies conducted concluded that it is estimated not to exceed 18% (Nantamu, 2011).

Ministry of Health-Uganda (2014) observed that, although Uganda has made significant progress towards achieving the different goals under SDGs like increasing access to skilled ANC, increasing access to HIV/AIDS 90-90-90 targets, eliminating mother-to-child transmission of HIV, etc. the final push towards achieving 80 to 100% of these SDGs goals will require intensified efforts of proven strategies, such as increasing active male partner participation moving away from promoting male involvement alone.

Therefore, social ecological model is used to underpin this study with a purpose that this model is suitable to help investigate and find out the factors influencing male partner's level and nature of active participation in skilled maternal health care services as it is claimed to be low and make also helps provide guidance for developing strategies or interventions that could successful enhance the level and nature of active male partner participation through social environments.

1.2 Problem Statement

Active male partner participation (AMPP) is globally recognised as a global public health concern today and is the reason why we see or hear a lot of campaigns geared towards increasing the promotion and implementation of AMPP in maternal health care services including in sexual and reproductive health care services and in other gender programmes nationwide in Uganda by government of Uganda through its health ministry and other implementing partners in the health sector.

However, in Lira district DHIS 2 105 monthly reports (2010-2017) on MNCH care services and other SRHS services show that, male partner's level of attendance is low, not exceeding 6% in some cases, that a good number of male partners tend to present at their spouse's 1st ANC visit only, attributed to the mandatory HIV testing policy of all expectant mothers; and very few or even none during their spouse's 2nd, 3rd and 4th ANC visits, in delivery and in post-natal. Attributed by the DHT team to be among others the reason why the district is struggling with MNCH preventable morbidity and mortality. It is against this background that

the researcher decided to find out the factors influencing active male partner participation in maternal health care services in Lira district.

1.3 Research Questions

1. What are the different ways/nature of male partners actively participating in skilled maternal health care services?
2. What is the level of male partner's active participation in skilled maternal care services?
3. What are the different factors influencing male partner's active participation in skilled maternal care services?

1.4 Conceptual framework

According to Reichel and Ramey (1987) a conceptual framework is a set of broad ideas and principles taken from relevant fields of enquiry. It is a research tool intended to assist a researcher in developing an understanding of the situation under investigation.

The study will utilize the conceptual framework illustrated below in order to meet the three objectives of the study. Active male partner participation will be conceptualized as being dependent on factors like health service factors, socio-cultural factors, socio-economic factors and service delivery.

Figure 1. Conceptual framework for assessing the factors influencing the level and nature of active male partner participation in maternal health care services in health facilities in Lira District

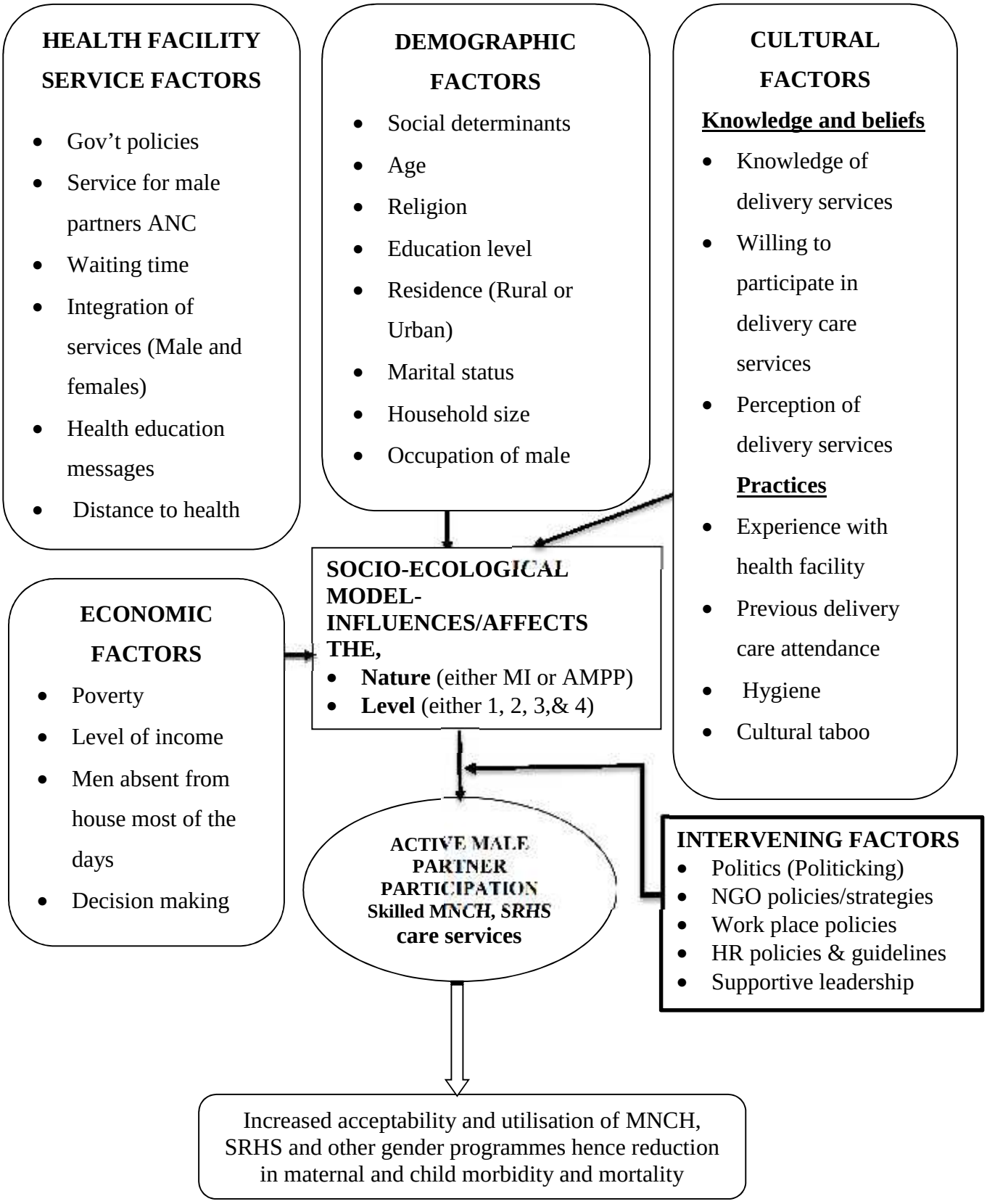


Figure 1: Conceptual Framework

Male partner's participation in skilled ANC, delivery care and postnatal care services of his spouse may be affected by his socio-demographic characteristics like age, educational level, occupation and religion. The type of marital union (formally married, unmarried or cohabiting), and whether or not they live together may also be important factors in determining the level of involvement.

Cultural norms that segregate gender roles may not encourage men to take part in activities that are tagged as feminine. Other family members like mothers and mothers' in-law may be seen as the ones responsible for issues related to pregnancy and delivery and so men may be reluctant to get involved. Some taboos may prohibit male involvement in some aspects of maternity care. Factors within the health facility may or may not encourage male participation in maternity care.

Health facilities' readiness to accommodate men who accompany their partners, male friendliness of the services and restrictions on the areas in the facility that can be accessed by men may influence male participation. Male participation ultimately leads to improved maternal health outcomes by increasing women's utilization of health services.

Therefore, examining the factors related to male partner participation in maternal health services will help to re-orient health services, create a supportive environment for both health workers, male partners and their expectant spouses, will inform policy formulation for male partner participation in skilled Antenatal care and in other reproductive and maternal and child health care services that will ultimately guide future reproductive and maternal and child health care programs.

4.0 Theoretical Model (s)

The Social Ecological Model

The study is underpinned by the Social ecological model. The has adopted the assumption of this model that emphasizes, the behaviours of human beings are influenced by multiple associated factors ranging from individual level to interpersonal level to organizational level

to community level and public policy level these associated attributed factors determines the behaviours how and why different people behave the way they do. These multiple levels of influencing factors interact across the different levels stated but social environments have much more impact on influencing how people behave and this explains why socio ecological model has gained much application in social sciences researches because currently intervention strategies have broadened to target influencing factors at various levels and it is against this background that this study adopted the assumptions of this model to help investigate and find out which the factors influencing the claimed low nature and level of male partner active participation in maternal child health care services in health facilities in Lira district. This recognition of the complex range of influencing factors that shape health behaviours can make the selection of interventional strategies daunting.

1.4.1 Goal

To contribute to increased level and nature of male partner's active participation in skilled maternal care services and in other SRH services.

1.4.2 Aim

To describe the level, nature and related factors to male partners' active participation in skilled maternal care services.

1.5 Objectives of the Study

1.5.1 Major Objectives

The main objective of this study was to find out the different factors influencing the nature and level of active male partner participation in skilled maternal health care services.

1.5.2 Specific Objective

1. To assess the different ways/nature of male partners actively participating in skilled maternal health care services.
2. To assess the level of male partner's active participation in skilled maternal health care services.

3. To find out the different factors influencing the nature/level of male partner's active participation in skilled maternal health care services.

1.6 Justification of the Study

Male partners have a strong influence on pregnant partners' health and their access to care. Their participation is critical in the delivery and uptake of maternal healthcare services and improving maternal and child health outcomes (Nesane, Maputle, and Shilubane, 2016).

Understanding the strategies that health care providers employ in order to invite men to participate in maternal health care is very vital especially in today's dynamic cultural environment. Effective utilization of such strategies is dependent on uncovering the salient issues that facilitate male participation in maternal health care (Kululanga et al. 2011).

The Ugandan policy on sexual and reproductive rights (2006) outline delivery care (components of safe motherhood strategy) as key interventions for improving maternal health. Currently, reproductive health interventions in Lira district are insufficient to improve male partner participation in delivery care. In addition, there are limited studies conducted in Sub-Saharan Africa on male participation in delivery care services.

1.7 Significance of the Study

The findings from this study generated evidence that can be referred to when reviewing the National strategy policy for male involvement and can lead to re-designing include active male partner participation.

The study findings can be used to re-orient health care services such as in MNCH, SRHS and other gender programmes in terms changing the modalities how health care services are delivered to its potential clients.

The study's ability to bring out the influencing factors to the observed low level and nature of active male partner participation in MNCH, SRHS and in other gender programmes, provoked immediate action to be taken by key stake holders such as district health officer or

district health teams, ministry of health and implementing partners to solve some of the most pressing attributes/issues said to be responsible.

Understanding level and nature of AMPP in public and private health facilities and getting to know which facility is doing better than the other and what factors are attributed to their better performance.

The results from this study may provide information that may contribute to the body of knowledge used in health education for the entire society thus enhancing knowledge and personal life skills of the entire community members. By so doing, it increases the options available to community members to exercise more self-control over their own health and over their own environments, and will help in making choices conducive for health through personal and social supports and development.

1.8 Scope of the study

1.8.1 Geographical scope

The study was carried out in health facilities in Lira District.

1.8.2 Content scope

The study examined the level, nature and factors related to male partner participation in skilled maternal care services in health facilities in Lira District. The respondents included male partners of expectant women, women and men who gave birth 12 months prior to this study who were present at the health facilities at the time of the study.

1.8.3 Time scope

The study was conducted from August 2017 to April 2018.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviewed literatures per every specific objective and focused on studies conducted on active male partner involvement/participation in skilled Antenatal care services. The literature search was first done at a global level to identify studies in this area, and later narrowed down to Sub Saharan Africa, Uganda, and specifically also searched for studies conducted in health facilities. Various research articles, books and conference papers which focused on men as partners from a gender equitable and family planning perspective were perused. The search was narrowed down to the search to specific areas of male partner participation in skilled ANC, delivery and postnatal care.

2.1 General overview of the active male partner participation

According to ManjateCuco, et al. (2015) perceived barriers for active male partners participation in skilled ANC as comprising of socio-economic constraints; health system factors; socio-cultural beliefs; gender inequity; limited knowledge of skilled ANC, delivery and postnatal care/PMTCT; mistrustful marriages and inadequate couples' communication patterns. According to, UNAIDS (2016), active male partner participation is defined as physical involvement but also includes active actual (real) engagement or participation in all decision making processes or stages in skilled ANC, delivery and postnatal care, active engagement and actual engagement (evidenced-base participation) by the health workers in all health related discussions, generation of ideas, decision making and taking on different roles of "shared responsibilities".

Male involvement on the other hand as defined by UNAIDS. (2011) as escorting or not escorting a partner (spouse) to seek skilled ANC services, delivery and postnatal care services. It may involve financial or transport support to spouses without actively taking part in each of the decision making processes stages in skilled ANC, delivery and postnatal care

services. In this study, male involvement in the skilled ANC, delivery and postnatal care was used to mean men included in ANC/PMTCT and in other sexual and reproductive health services (including voluntary counselling and testing) in all phases of ANC, delivery and postnatal care services as one nature of male partner participation.

The study was underpinned using the social ecological model adopting its assumptions that people's behaviours are influenced by multiple levels of factors with the social environments said to have much impact and the other factors being; individual, interpersonal, organizational, community and public policy which is in consistent with the social cognitive theory where environment is seen to be the bigger influencer of human behaviours within their own societal settings.

2.2 Nature of male partner participation in skilled maternal care services.

Adopting the ICPD's definition of shared responsibility, men's and women's responsibilities and participation collaboratively allows them to share ownership and resources in a "Win-Win situation" to benefit each and every one of them in their family and community at large. This implies that everyone gives a little or contributes by playing their individual expected societal roles. Itisalso worth noting that men can play both direct and indirect roles

The direct roles most frequently stated were financial support (Byamugisha, Tumwine, Semiyaga, and Tylleskar, 2010; Kwambai, et al. 2013; Larsson, et al. 2010; Nkuoh, et al. 2010; Theuring, et al. 2009), followed by decision-making, responsibility over women's health (Koo, Makin, & Forsyth 2013a; Kwambai, et al. 2013; Larsson, et al. 2010; Theuring, et al.2009) and help with housework throughout pregnancy. (Kwambai, et al. 2013; Nkuoh, et al. 2010; Theuring, et al. 2009).

According to Aarnio, Aarnio, Olsson, Chimbiri and Kulmala (2009), indirect support could be observed through improvement of communication between couple's faithfulness during pregnancy; and support to HIV-positive women. Aarnio, et al. (2009) also observed that financial support was stated among the indirect role the men played. Most men reported

believing that their main role was that of a breadwinner (Larsson, et al. 2010; Musheke, Bond and Merten, 2013) and provider of money for health expenses, to pay skilled ANC/PMTCT clinic fees, and avail food for the family well-being.

Nevertheless, the men´s role of guaranteeing family income and having to work is often used as an excuse to not accompany their wives to skilled ANC/ PMTCT clinics. (Kwambai, et al. 2013; Larsson, et al. 2010; Musheke, et al. 2013).

According to some men's statements, as part of their responsibility (Aarnio, et al. 2009; Theuring, et al. 2009) and in spite of their awareness of women's financial dependence, they assume that women need their permission to go to ANC/PMTCT sessions because only male partners can decide which clinic to attend and which ANC/PMTCT care they can afford (Kwambai, et al. (2013). Other men perceive that they have to persuade women and sometimes obligate them to attend ANC/PMTCT clinics or see a traditional birth attendant in reaction to women's careless health conduct, ignorance or laziness (Kwambai, et al. (2013).

Few men see their role as extending to sharing responsibility during pregnancy, childbirth and child care (Nkuoh et al. 2010), helping with cooking and housework (Nkuoh et al. 2010; Theuring et al. 2009) and improving women's diets. (Kwambai, et al. 2013).

Other reasons included; - the inability to afford transportation particularly for two people (Koo, et al. 2013a; Duff, et al. 2012; Byamugisha, et al. 2010; Larsson, et al. 2010; Nkuoh, et al. 2010; Orne-Gliemann et al. 2010; Reece et al. 2010),

Lack of transport (Tweheyo et al. 2010), the need to pay for HIV testing (Duff et al. 2012), pay for care and drugs (Larsson et al. 2010; Reece et al. 2010), pay illegal extra charges (Larsson et al. 2010; Orne-Gliemann, et al. 2010; Reece et al. 2010), and financial conflicts with other urgent household needs. (Duff, et al. 2012).

Mbonye, et al. (2010) and Koo, et al. (2013a) therefore, concluded that men's communication about reproductive health matters with his spouse is a means of taking on shared responsibilities. Villar-Loubet, et al. (2013) and Aarnio, et al. (2009,) described it as a mean

for common decision making concerning sexual and reproductive health services like HIV testing with their spouse share ideas about sexual issues. Madiba and Letsoalo, (2013).

According to studies conducted by (Kasenga, et al. 2010; Mbonye, et al. 2010; Oladokun, et al. 2010; Peltzer, et al. 2010; Gilles, et al. 2011; Maman, et al. 2011; Kalembo, et al. 2013; Koo, et al. 2013a; Kwambai, et al. 2013; and Villar-Loubet, et al. 2013) observed that shared responsibilities included male partners encouraging their expectant spouses to take part in different skilled antenatal care activities such as for HIV counselling and testing. Musheke et al. (2013) observed that also issues such as the male partner's supportive attitude to his spouse's disclosure of her HIV+ status or generally loving and caring attitude toward an HIV positive spouse as observed by (Nkuoh, et al. 2010; Maman, et al. 2011; Musheke, et al. 2013) and finally taking up in PMTCT/eMTCT services care programs implementation during prenatal, perinatal and postnatal phases shows male partner's importance in decision making for family health requires active male partner participation in these activities.

Auvinen, (2014) observed that spousal communication and taking care of the family was concluded as a means of shared responsibility. According to Aluisio, et al. (2010); Nkuoh, et al. (2010); Tweheyo, et al. (2010); Mohlala, et al. (2011); and Koo et al. (2013a), male partner's attendance in skilled Antenatal clinic with his pregnant spouse, for different reasons, has been for many times considered as providing a venue for male active participation like accompanying expectant spouses in skilled ANC clinic and by taking part in health education and counselling and testing for HIV and his acceptance for HIV screening.

Gilles et al. (2011) observed that encouragement and reminding their spouses of laboratory monitoring and reminding of skilled Antenatal care appointments as observed by (Kalembo, et al. (2013) and Kwambai, et al. (2013) while Peltzer, et al. (2010.

According to Auvinen, (2014); Mohlala, et al. (2011); and Kalembo, et al. (2013), practicing a safe sexual life was commonly viewed to mean that a male partner is faithful to his spouse

and meant that a male partner uses condoms in sexual intercourse in case there is a transmission risk which is a strong evidence to show shared responsibilities among the couples.

Maman, et al. (2011) also found that financial provision for the expectant spouses and for nursing mothers and supporting the wives in jointly attending to all the four ANC visits and adhering to the PMTCT of HIV programs and midwives also emphasized the male partner's role as a provider who makes it possible for their spouses to reach health facilities have all been considered as shared responsibilities and is a male partner's mean for direct active participation in skilled Antenatal care and in other sexual and reproductive health services.

Mburu, et.al. (2012) observed that among other factors, men's uncommon behaviours in ANC, delivery and postnatal care programs contribute to poor health care services outcomes.

According to Nkuoh, et al. (2010); Falnes, et al. (2011); and Larsson, et al. (2010), most expectant mothers complained of their male partners' unsupportiveness to ensure they uptake of Antenatal care services and other reproductive health care services and adhere to all the medical instructions told to them by medical doctors.

Nompumelelo, et al. (2017) observed that adherence to medical guidelines/standards is still a challenge to most women in patriarchal societies simply because most men don't actually actively share responsibilities.

2.3 Level of male partner participation in skilled maternal Care services.

According to UNAIDS (2011) active male partner participation has become part of the global response for improving sexual reproductive health and rights (SRHR). In response to this reality, and as part of its woman-centred approach, the ICPD declares that "efforts must be taken to secure the active participation and support of men in all aspects of SRHR and related programmes to address HIV and gender related discrimination that impedes service access and uptake as well as client retention"

Sporadic jobs and casual labour, jobs with little control of assignments that most men in developing countries are engaged in (Reece et al. 2010) were frequently cited as barriers to level of participation of male partners. The belief that ANC/PMTCT was only for women and children had negative impact at men´s workplace leading them not to request leave to attend PMTCT clinics (Theuring, et al. 2009). Originally men perceived ANC/PMTCT clinics as unfriendly (Kwambai, et al. 2013; Koo, et al. 2013; Orne-Gliemann, et al. 2010; Larsson, et al. 2010), and dominated by women as both clients and care providers (Koo et al. 2013) and men felt totally ignored. (Kwambai, et al. 2013).

Peacock et al. (2009) noted that because Sexual and Reproductive Health programmes and services have been focused primarily on women, men have often lacked information to make informed decisions about healthy behaviours and this has had significant impact on the roles they have often played in promoting overall family health, including accessing HIV prevention, care and treatment services.

Studies demonstrate that when given the opportunity to participate in SRHR programmes, such as family planning and the PMTCT programmes, men wish to be positively involved in promoting the health of their families and communities. Results from various studies show that men's constructive engagement yields positive results for the health of women, children and entire families.

According to a qualitative study conducted by Lugina. (2008) in Tanzania, men aged 20 to 34 years desired to escort their wives to skilled ANC and labor wards. However, when they went with their wives, the nurse-midwives asked them to remain outside the examination or labor-rooms, making them bored and discouraged.

A related study conducted by Ditekemena, et al. (2012) pointed out that there's a relationship of poor communication between men and their female partners and poor male participation. This is more so when such a relationship has been triggered by some health facility factors that make men to feel left out of antenatal care services although effort has been to have them

actively involved. On the other hand, good couple communication was associated with high HIV status disclosure and support between husband and wife.

Ditekemena, et al. (2012 in their study while assessing the issues about space and men friendly health care services, observed that more friendly and convenient venues for men are needed in order to actively engage male partners in health related discussions together with their spouses. The lack of space to accommodate male partners in skilled ANC clinics was also reported to adversely impact male involvement/participation. Clinics are often unable to concurrently accommodate pregnant women and their spouses because of a lack of space.

Gender specific services to address uniquely male issues do not exist in our health systems. Targeted interventions for men only, such as tailored messages, specific health education sessions to address men issues alone are absent. Innovative strategies to identify male friendly venues would be valuable for increasing male partner participation in antenatal care and in other reproductive and maternal and child health care services. In a similar study conducted in Rwanda, it was shown that essential PMTCT services were often not proposed by health providers thus contributing to the weak PMTCT and ARV prophylaxis uptake among clients. Health services providers are often overworked, stressed, and have to work in an infrastructure with severely limited resources. In such context, the quality of services is compromised and taking care of participating male partners is considered an additional burden.

Byamugisha, et al. (2010) in a cross-sectional study conducted in Eastern Uganda noted that health care workers in some occurrence do not allow men to enter the skilled antenatal clinic with their pregnant partners. The men have continued to express the view that they do not feel welcome and comfortable in prenatal clinics, and in some settings, there are policies that restrict men’s access to clinics. The structural design of antenatal care clinics does not address the issues of the flow of clients creating congestion in specific areas, with no space to accommodate the women and their partners. This is similar to a study conducted by

Theuring,et al. (2009) in Mbeya region of Tanzania where some of the men who had followed their wives to the antenatal care were in fact refused access by health care providers. Therefore, for one reason or another lack of meaningful participation due to failure by health workers to engage male partners who escort their spouses to receive Antenatal care services has continued to demoralize the men from active taking part in skilled maternal care services of their spouses leading to a constant low male partner participation in maternal care services. Enhancement of male partner participation through engaging them in actual health related discussions with the health workers together with their spouses strengthens active male partner participation.

2.4 Factors influencing male partner's active participation in skilled maternal health care services.

2.4.1 Socio-cultural factors

Larsson, et al. (2010) and Orne-Gliemann, et al. (2010) found out that men are often identified as decision makers in all aspects of day-to-day life. From a socio-cultural perspective, traditional systems in both rural and urban settings in most Sub-Saharan Africa (SSA) communities are deeply rooted in male authority over women's and children's health, particularly in its sexual and reproductive health aspects of their women.

Larsson, et al. (2010) and Orne-Gliemann, et al. (2010) noted that this is why male partner participation in skilled Antenatal care and PMTCT services and in other reproductive and maternal and child health care services is essential in a patriarchal society of developing countries where men are decision makers of the household. The reason being men hold social and economic power and have tremendous control over their partners, especially in developing countries and they decide the timing and conditions of sexual relations, family size, and whether or not their spouses will utilize available health care services.

In WHO, UNFPA, (1995) and United Nations, (1996), men's active participation in the skilled ANC and in the lives of their expectant spouses and children has been shown to have

lasting effects. However, Uganda has culturally dynamic and patriarchy societies. Men decide the timing and conditions of sexual relations, family size, and whether or not their spouses will utilize available health care services (Dharma, 2013).

Most of the researches conducted on the participation of male partners in ANC, delivery and postnatal care services, hold strong opinion that cultural beliefs and gender role play a big role in influencing men behaviour towards antenatal services. Men do not seek health information and services due to traditional notions of masculinity, where asking for help from a nurse or doctor is viewed as a sign of weakness. Many men feel it is their right to refuse contraception, to allow their partners or even discuss FP (Engender Health, 2008). Deep-seated socio-cultural ideas constitute a hindrance to male involvement in ANC/PMTCT, where pregnancy is seen as the sole responsibility of a woman, and antenatal clinic was perceived to be a female arena not acceptable for a man to enter (Falnes,et al. 2011).

2.4.2 Socio–economic factors

According to Kalembo, (2013); Conkling, et al. (2010) and Theuring, et al. (2009), because of the social and economic power that men hold within their communities especially in the SSA, many studies conducted in SSA on male partner involvement have reported positive benefits of male involvement in skilled Antenatal care and in other reproductive and maternal and child health care services in developed and developing countries. Such effect has been observed to include: increased maternal access to antenatal and postnatal services; discouragement of unhealthy maternal practices such as smoking; improved maternal mental health; increased likelihood of contraception usage; and reducing of stress, pain and anxiety during delivery. The culture of involving male partners is an important factor in reducing PMTCT/eMTCT refusal by women, as well as delayed enrolment and dropout rates but also their MPI is seen to increase male partner's opportunities for couple HIV testing and counselling and eventually early HIV detection and initiation on ART.

Larissa, et al. (2014), explained that beyond the physical and health systems associated factors, women's low social status negatively impacts utilization of antenatal care services. As compared to men, women often lack decision-making power to allocate resources for healthcare seeking, particularly in contexts where men determine. This can prove to be problematic particularly in households where men underestimate the importance of antenatal care. Even following skilled ANC consultation, women possess limited means and authority to implement healthy home practices that direct effect on achieving the development goals.

Asiimwe, (2010) noted that most women attend skilled ANC only once instead of the recommended minimum of four times, and some never return for delivery. This has been attributed to a number of factors, notably among many is husbands deciding when and where a woman is to get skilled ANC and delivery care.

Nyane (2007) observed that, men affect utilization of skilled ANC and delivery care services in Uganda and this was confirmed by a study that was conducted in Tororo where it was observed that some pregnant women dropped out from next skilled ANC visits when asked to come with their partners. In Kasolo and Ampaire, (2000), poor knowledge of what is done at the health facility, coupled with poor communication skills among spouses and health workers as well as the low status of women in the community were noted to greatly worsen women's levels utilization of skilled ANC services in Uganda.

Another reason reported for low active male participation in maternal health care is that many men feel marginalized and left outside their contact with the mother and child care services. In effect men's involvement in the maternal health care system often stops at the doors to the skilled ANC clinic, yet to exclude men from the information on the benefits of skilled antenatal care, counselling and services is to ignore the important role men's behaviours and attitudes play in a woman's maternal health choices.

Some men feel it's their duty to facilitate their wives in terms of transport and if they do not have means of transport they see no point in escorting them while both are walking. Yet in

many situations in Africa where the man is economically in position to provide the basic necessities of life, he tends to have more than one wife, which also negatively affects his willingness and ability to escort the wife to seek care. To accommodate this problem, it has been suggested to offer services after working hours or on weekends and to reduce waiting time for men/couples (Bolu, et al. 2007) as cited in Theuring,et al. (2009).

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

Communicating with men has been reported by some researchers to pose challenges for programmes, which historically have focused on serving women (Young and Kol, 1999). It is not easy to design messages and materials that men find persuasive, but that also promote gender equality and women empowerment. In Zimbabwe, most men misinterpreted campaign messages promoting male involvement to mean that decisions should solely be left to men (Young and Kols, 1999).

Men also continue to state the long distance covered, the long waiting time, social and cultural barriers, limited awareness, and unfriendly environment are important factors influencing the use of public health services and actually demand for other services. There is lack of skills by the service providers in counselling male clients and couples (Ndong,et al. 1999).

According to Vermeulen, et al. (2016); men perceived antenatal care as important for pregnant women though men's participation is often found to be low , most husbands have passive attitudes regarding their own participation and barriers attributed included: traditional gender roles; lack of knowledge; perceived low accessibility to join antenatal care visits and previous negative experiences in health facilities.

Strategies to have male partners actively participate in maternal child health care services and in other sexual and reproductive health services should aim at raising their awareness about emergency obstetric conditions, and engaging them in birth plans and complication readiness to ensure both men and women are empowered. Male involvement enables men to support their spouses to utilize obstetric services and the couple would adequately prepare for birth complications (Dharma, 2013).

Active male participation is believed to reduce delay in the decision to seek care; delay in reaching care; and delay in receiving care. This is because a male partner can play a crucial role especially in the first and second phases of delay in developing countries and thereby positively impacting on birth outcomes (Dharma, 2013).

Therefore, for all the positive reproductive outcomes that is believed to arise due to male partner participation to be achieved, the conduct of health workers who come in contact with these male partners, their expectant spouses and with their children while providing these health care services, need to be improved. The role of promoting positive health outcomes in households and communities is very crucial and must be addressed at all levels. Therefore strengthening male participation by adding community-level strategies to engage men have a greater impact than pursuing facility-based strategies alone since there is evidence of significant health benefits of male participation (MoH, 2014; WHO, 2010).

Some traditions considered women as inferior to men in social status (Koo et al. 2013b) and they were not allowed to lead their male partners (Falnes, et al. 2011; Larsson, et al. 2010; Nkuoh, et al. 2010), or tell them what to do (Falnes, et al. 2011). Inviting men to a female gathering and giving them their partners ANC/PMTCT information (Koo, et al. 2013a; Larsson, et al. 2010) might be interpreted as handing over power to women. Men use their authority to devalue women's demands for their involvement in ANC/PMTCT (Falnes, et al. 2011; Larsson, et al. 2010).

In some situations, women's HIV testing is considered an indication of prostitution or adultery (Walcott, Hatcher, Kwena and Turan, 2013; Duff, et al. 2012; Falnes, et al. 2011; Larsson, et al. 2010) and sometimes, regardless ofthe results, could lead to domestic violence. (Duff, et al. 2012; Falnes, et al. 2011; Mlay, Lugina and Aarnio, et al. 2009).

Cases of sero-discordance, involving positive woman can culminate in divorce. If the man is positive, the consequences are lighter often involving quarrels and denial. (Larsson, et al. 2010).

Some communities perceived male presence at skilled ANC/PMTCT clinics as abnormal. (Larsson, et al. 2010; Nkuoh, et al. 2010; and Theuring, et al. 2009), making men susceptible to criticism and doubt about their masculinity, their power over their wives, and a sign of weakness (Byamugisha, et al. 2010), bewitchment (Nyondo, Chimwaza and Muula, 2014), jealousy (Larsson et al. 2010), and serving as an unwelcome example for other couples. Fearing peers' hostility (Falnes, et al. 2011; Larsson et al. 2010; Orne-Gliemann, et al. 2010) and shame (Nkuoh, et al. 2010) to be the only male present (Falnes, et al. 2011), men generally do not go to ANC/PMTCT clinics. Men´s visit to clinics could be eventually justified if accompanying their sick wives (Mohlala, et al. 2012).

Byamugisha, et al. (2010) in a cross-sectional study conducted in Eastern Uganda reported that health care workers in some incidences did not allow men to enter the skilled antenatal clinic with their pregnant partners. The men have continued to express the view that they do not feel welcomed and comfortable in prenatal clinics, and in some settings, there are policies that restrict men's access to clinics. They further move on to complained about the structural design of antenatal clinics which are often congested, with no space to accommodate the women and their partners. This is similar to the situation in Mbeya region of Tanzania where some of the men who had followed their wives to the antenatal care were in fact refused access by health care providers (Theuring,et al. 2009).

However, most health-care professionals' surveyed previously reported being in compliance with their ethical obligations despite the lack of resources, discriminatory behaviourand attitudes towards patients exist among a significant proportion of health-care professionals. Inadequate education especially up-to-date new medical information about different type of medical conditions like HIV/AIDS and a lack of protective and treatment materials appear to contribute to these practices and attitudes which tend to push the male partners from actively participating in their family-health (Reis et al, 2012).

Therefore, enhancement of male partner participation through proven strategies is necessary in culturally dynamic societies like Uganda to improve the women's health, children's health, community health and societal health at large and reduce maternal and neonatal morbidity and mortality (Dharma, 2013).

2.5 Health system factors and its dynamics in active male partner participation in skilled maternal care services.

The health system has been shown to be critical on decisions to attend or not to attend for women overall but also for men. A qualitative study which included 16 FGDs with men and women conducted by Reece, Hollub, Nangami and Lane. (2010) in the western Kenya to examine reasons for men's non-involvement in PMTCT initiatives and other HIV-related services found health system barriers such as low quality couple's counselling, inflexible weekend clinic hours, community education regarding HIV-related services at clinics containing strong language and clinics not being male-friendly.

In Byamugisha, Tumwine, Nalu and Tylleska. (2010) carried out in Mbale district in the Eastern Uganda cited similar health system barriers to male involvement which included the structural setup of antenatal clinics and health-workers not being client-friendly.

Clinics were too centralized in Eastern Uganda (Byamugisha, et al. 2010) and far from communities and work places. (Byamugisha, et al. 2010; Duff, et al. 2012; Larsson, et al. 2010; Nkuoh, et al. 2010; Reece, et al. 2010).

It was also observed by Koo, et al. 2013a, Duff, et al. 2012, Ome-Gliemann, et al. 2010,and Tweheyo, et al. 2010 that, work commitments create overlap of the clinic appointment schedules and working hours affect the level of engagement health workers can accord to men during ANC visits.

According to Koo, et al. (2013b), health workers' attitudes were described by men as embarrassing, rude, and harsh, use of abusive words either to pregnant women alone or in the presence of their partners.

In Uganda, despite most households (80%)(UBOS, (2016) being within 5km radius from their nearest health facility, expectant mothers/women continue to report late for skilled ANC and deliver outside the health facilities and this was also noted by Kasolo and Ampaire, (2000) in their study.

Dharma, (2013) added that all emphasis should be put in enhancing active male participation in skilled ANC, delivery and postnatal care services. It was also noted that if men are enabled to support their expectant spouses to utilize obstetric services then couples would adequately prepare for birth complications.

Dharma, (2013) goes ahead to appreciate that if Uganda can achieve to bring all men to start actively participating in all aspects of their family's health, would lead to a massive reduction in all three phases of health-services access sources of delay.

Therefore, Dharma, (2013) concluded that in order for women to be able to access and utilize skilled ANC services and other reproductive and maternal and child health care services, enhancement of male partner participation through proven strategies is necessary in culturally dynamic societies like in Uganda through male partner engagement in health related discussions, generation of ideas, actively participate in decision making processes and share responsibilities with their spouses and the health workers needs to be emphasized at all levels of skilled ANC delivery in order to change the current continuous trends of low male

participation and to improve the women's health and reduce maternal morbidity and mortality.

2.6 Suggestions given for improving male participation.

According to Byamugisha et al. 2010b the following suggestions were made from their study:-More time spent sensitizing men about the benefits in skilled antenatal care, delivery care and postnatal care services, conduct refresher trainings for health workers i.e. midwives and nurses and other health cadres to include; customer care skills, the government to build more health units closer to the people where antenatal care could be offered, welfare of the staff to be improved e.g. provision of better remuneration, more staff to be recruited into the health service and midwives to write on the antenatal cards informing the men to come with their wives on subsequent ANC visits.

2.7 Manifestation of commonly accepted norms of male partner active participation

Various studies have suggested some of the activities that have been considered to manifest as active male partner participation in skilled antenatal Care and in other sexual and reproductive care programs. Mbonye, et al. (2010) and Koo, et al. (2013a) concluded that male partner participation was seen as a mean to communicate about reproductive matters with his spouse. Villar-Loubet, et al. (2013) and Aarnio, et al. (2009,) described male partner participation as a mean for common decision making concerning HIV testing where spouses shared ideas about sexual issues Madiba and Letsoalo (2013).

Auvinen (2014) concluded that, spousal communication and taking care of the family was a male partner's method of participation in the common view of both men and midwives. The prominent role of a man in such spousal communication is recognizable. Active participation of male partners increases spousal communication about sexual risk and behaviours change (Desgrees-du-Lou, et al. 2009a).

According to Aluisio, et al. (2010); Nkuoh, et al. (2010); Tweheyo, et al. (2010); Mohlala, et al. (2011); and Koo et al. (2013a) male partner's attendance in skilled antenatal clinic with

his pregnant spouse, for different reasons, has been for many times considered as providing a venue for male active participation like accompanying expectant spouses in skilled ANC clinic and by taking part in health education and counselling and testing for HIV and his acceptance for HIV screening have been considered forms of male partner participation in skilled ANC services.

Other studies conducted by Gilles et al. (2011); Maman, et al. (2011); Kalembo, et al. (2013); Koo et al. (2013a); Kwambai, et al. (2013); and Villar-Loubet, et al. (2013) concluded that encouraging their expectant spouses to take part in different skilled antenatal care activities such as for HIV counselling and testing. Also, Madiba and Letsoalo, (2013) and Musheke, et al. (2013) observed that issues such as the male partner's supportive attitude to his spouse's disclosure of her HIV+ status or generally loving and caring attitude toward an HIV positive spouse as it was also observed by Nkuoh, et al. (2010); and Musheke, et al. (2013) in their studies and they concluded that taking up in PMTCT/eMTCT services care programs implementation during prenatal, perinatal and postnatal phases shows male partner's importance in decision making for family health requires active male partner participation in these activities.

Gilles et al. (2011) observed that encouragement and reminding their spouses of laboratory monitoring and reminding of skilled Antenatal care appointments as observed by Maman, et al. (2011); Kalembo, et al. (2013) and Kwambai, et al. (2013) while Peltzer, et al. (2010) observed that reminding their spouses about their medical treatment regimens and Kasenga, et al. (2010); Kalembo, et al. (2013) and Kwambai, et al. (2013) also concluded that reminding their spouses about their hospital delivery are means of male partner active venues for participating.

According to Auvinen, (2014); Mohlala, et al. (2011) and Kalembo, et al. (2013) practicing a safe sexual life was commonly viewed to mean that a male partner is faithful to his spouse

and meant that a male partner uses condoms in sexual intercourse in case there is a transmission risk.

Maman, et al. (2011) financial provision for the expectant spouses and for nursing mothers and supporting the wives in adhering to the PMTCT of HIV programs because male partner participation has been more pronounced in PMTCT clinic than in general health care and midwives also emphasized the male partner's role as a provider who makes it possible for their spouses to reach health facilities have all been considered as the male partner's means for direct active participation in skilled Antenatal care services.

2.8 Health systems challenges most likely to be encountered in enhancing active male partner participation in skilled maternal care services

According to Walston and USAID, (2005) observed that a number of health or health-related policies do not specifically refer to active male partner participation that "extends beyond physical involvement to include actual engagement of male partners by the health workers in health related discussions, generation of ideas, decision making and shared responsibilities" instead emphasizes male involvement which mainly refer to the physical presence of a male partner and fail to offer suggestions for how to have men involve and actively participate in ANC and in other sexual and reproductive health services uptake.

Adams et al., (2003); and Diallo et al., (2003) defined health workers as all people engaged in actions whose primary intent is the promotion, protection and improvement of the health of the population This is consistent with the WHO definition of health workers as comprising of all people engaged in activities with the primary goal of enhancing or improving health of their communities (The world health Organization (WHO) definition of a skilled Health worker, 2008).

Walston and USAID,(2005) concluded that most health or health related programs lack clarity as to how active male partner participation should be promoted and implement their

services clearly with the unspoken assumption that services are equally accessible to both sexes.

Walston and USAID, (2005) also observed that even gender-related policies tend to overlook the concept of equality and the role of men in actively promoting women's access to services be it health or other social services and development opportunities. Therefore, Gender roles have been found to be a barrier to male participation in the previous studies.

Also, UNICEF , (2016) also observed that challenges related to lack of male-friendly services, socio-economic factors, cultural beliefs and structural barriers to male involvement and participation has been widely documented, however, local barriers to active male partner participation were not well known.

2.9 Impact of active male partner participation in maternal care services.

MoH Uganda, (2005) stated that skilled Antenatal care clinics are used to educate or pass information to the pregnant woman like on nutrition, family planning, immunization, breast feeding, personal and domestic hygiene, environmental health where by male involvement and participation will be of great importance in rendering these services. Other services include immunization with tetanus toxin at least two doses, general health status assessment to detect or prevent any complications, and Intermittent presumptive therapy.

Marlene, et al. (2015) and Nantamu, (2011) also mentioned that many studies conducted in sub-Saharan Africa (SSA) besides highlighting the positive benefits associated with active male partner participation in skilled Antenatal care and in other reproductive and maternal and child health care services, observed that male partners are rarely present in skilled Antenatal care services and in other reproductive and maternal and child health care services.

Sharing the insights made by Ornella, et al. (2014) in their study that revealed that active male partner participation in family and community is crucial for healthy home behaviours during pregnancy and has been shown to be a major determinant of use of skilled ANC services and other sexual and reproductive health programs. And establishing links between

the community and the facility can increase utilization of health services, such as skilled ANC, among others and will impact positively on maternal and neonatal mortality as well as stillbirths reducing the rates remarkably. This is made possible since skilled ANC services attended provides both expectant mothers (women) and their families (the male partners and children) with appropriate information and advice for a healthy pregnancy, safe childbirth, and postnatal recovery, including care of the new-born, promotion of early, exclusive breastfeeding, and assistance with deciding on future pregnancies in order to improve pregnancy outcomes. (Ornella, et al. 2014).

Dharma, (2013) observed that Uganda has a potential of experiencing a massive reduction in all the three phases of health services access sources of delay; delay in the decision to seek care; delay in reaching care; and finally, delay in receiving care. Male partners play crucial roles especially in the first and second phases of delay in developing countries and thereby positively impact on birth outcomes.

Therefore, according to Ornella, et al. (2014) if Uganda achieved to make skilled ANC and other sexual and reproductive health services inclusive for all male partners by providing men's-friendly health services (male partners), will increase their opportunities and willingness to actively participate in all skilled ANC and in other sexual and reproductive health programs**,** why? Because men (male partners) become aware that effective skilled ANC and other sexual and reproductive health packages depends on competence health care providers in a functioning health system with referral services and adequate supplies and laboratory support and more so the active participation of male partners of these expectant spouses/mothers.

Ornella, et al. (2014) therefore concluded that male partner or the mothers or the mother-in-law should be welcome to attend an ANC session with the woman. Their support can help the woman follow the skilled ANC recommendations, encourage shared decision making, and improve the health for both mother and new-born.

2.10 Guidelines to enhance active male partner participation in skilled maternal and in other sexual and reproductive health services in Uganda.

In 2014 the Uganda government led by the ministry of health acknowledged the low continuous current trend of male partner participation in ANC and in other sexual and reproductive health services and launched a National strategy policy and guidelines to provide a policy framework and guidance in the following areas to see that active male partners participation is increased in ANC and in maternal child health, sexual and reproductive health rights (SRHR), including HIV/AIDS.

According to ministry of health, (2014) the national strategy policy and guidelines is meant to re-orient health systems by focusing on the following key areas of constructs that includes; capacity building and supportive supervision for delivery of quality male-friendly services, coordination, networking and partnerships for promoting male involvement and participation, research and documentation of male involvement and participation programme and lessons learned, monitoring and evaluation of male-friendly health services, communication and community, engagement for male involvement and participation, and leadership and accountability at all levels.

Also, Vermeulen et al. (2016) added that although several barriers impede male participation during antenatal care, men's internal motivation and attitudes towards their role during pregnancy was generally positive. Increasing community awareness and knowledge about the importance of male involvement and increasing accessibility of antenatal clinics can reduce some of the barriers.

2.11 Summary of the literature review and knowledge gap.

Nature of male partner participation

After critical appraisals of the literatures, little is evidenced in the different study findings reviewed shown the different nature of male partner participation in skilled ANC, delivery and postnatal care services; most studies only looked at escorting spouses and financial support, yet there are a lot of aspects involved in nature of active participation.

Borrowing from the ICPD 1994, the nature of male partner participation comes from the understanding of what shared responsibility is actually, men's and women's responsibilities in active participation is collaborative and allows both sexes to achieve shared ownership and resources in what can be called a "Win-Win situation" to benefit each one of them. This implies that every one of them should give a little contribution by playing their individual expected social roles however; it is worth noting that men can play both direct and indirect roles such as financial support, decision making regarding their spouses' health, house work, indirectly by improving intra-spousal communication regarding family health among others.

Level of male partner participation

Only three studies were found related to this topic and conducted in Uganda, out of which they mostly centred on men's involvement and HIV blood testing only not active participation though involvement is an entry point to active participation and studies were conducted in HIV clinics especially in regards to PMTCT, which is just one program in skilled maternal health care services and their findings revealed that men are rarely present so very low in skilled maternal child health care services, yet according to UNAIDS, (2011) male partner active participation is advocated for more right now globally because it has become part of the global response for improving sexual reproductive health and rights (SRHR), therefore, efforts must be taken by all governments to secure active participation and support from male partners/men in all aspects of SRHR and its related programmes.

Factors influencing male partner's level and nature of active participation in skilled maternal child health care services.

According to the literatures reviewed numerous factors are attributed to be responsible to the trend of male partner level and nature of participation and herein are a few of such factors:- the fact that male partners/men are often identified as decision makers in all aspects of day-to-day life, the socio-cultural perspective of traditional African systems in both rural and urban settings in most Sub-Saharan Africa (SSA) communities are deeply rooted in male

authority over women's and children's health, particularly in sexual and reproductive health aspects of their women, yet their level and nature of participation is low and hardly evidenced by naked eyes.

Some studies said that beyond the physical and health systems associated factors, women's low socio-cultural or socio-economic status negatively impacts on their utilization of skilled ANC, delivery and postnatal care services. Compared to male partners/men, women often lack decision-making power to allocate resources for healthcare seeking, particularly in contexts where men determine whether and under what conditions their spouses will use health services. This can prove problematic particularly in households where men underestimate the importance of antenatal care. Even following skilled ANC consultation, women's limited means and authority to implement healthy home practices have hindered development goals.

Knowledge gaps

Earlier studies mainly studied male involvement not active male partner participation which according to this definition of AMPP adopted by this study reveals that male involvement is an entry point to active male partner participation, so this study is interested in active participation and is therefore the centre of this study. Secondly, the few studies focused their study interests on HIV/PMTCT clinics forgetting the other health care services provided in skilled maternal child health care clinics. Thirdly, the few studies focused on attendance in Antenatal care clinic and HIV/PMTCT clinic and touched nothing on the nature of male partner's participation in these clinics.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter discusses in detail the research design/methodology that was used for this study. According to Brink, Van der Walt, and Van Rensburg, (2006, pp. 191), the research methodology section "informs the reader of what the researcher did to solve the research problem or to answer the research question". The Research Design, study area, study population, sampling size determination, sampling procedures, research instruments, Measurements, data collection procedure, data managements, data analysis, ethical considerations, assumptions and limitations of the study and disseminations of results are discussed in this chapter.

3.1 Study area

The study was carried out in Lira district, in Northern Uganda. Reason being Lira like any other district in Uganda is faced with many incidences of maternal death, neonatal death, and postnatal complications. Lira is also a central business leading district in Lango-regions with the highest population in the region as projected by National Population and Housing Census/UDHS, (2014) and has the highest numbers of immigrants from all corners of neighbouring districts and villages and Lira also being the referral point for all neighbouring district for all complicated maternal cases.

Lira district is bordered by Alebtong district to the North-East; Otuke district to the East; Kole and Oyam districts to the West; Apac district to the West, Dokolo district to the North-East; and Kaberamaido district to the South-West. The district has one regional referral hospital; two health centre fours and six health centres.

The national population and Housing Census in 2014 estimated the population of Lira District at 410,516 with males and females estimated to be 196, 891 and 213, 625 respectively.

3.2 Research Design

The study was a cross-sectional descriptive study because it provides a snapshot descriptive information of the experience of the study subjects at a particular point in time and able to investigate relationships. The study employed both quantitative and qualitative methods of data collection and analysis. The study was carried out in health facilities in Lira District, Northern Uganda.

The required information was obtained from men aged 18 years and above and their pregnant spouses/mothers using interviewer administered structured questionnaire and four focus group discussions were conducted with separate male and female groups to help explore further cultural norms, perceptions of gender roles, perceptions of male friendliness of health facilities and attitudes of peers and the community at large to male participation in skilled ANC. Observations were carried out from the selected health facilities where male partners, their spouses were receiving care from health workers in ANC, delivery and postnatal clinics.

3.3 Study Population

Ngechu (2004); defined study population as the whole population targeted for a study or where the study is going to be conducted. The study population for this study is the reproductive age groups of females from the age of 15 to 49 years of age in Lira district and specifically here the researcher looks at the mothers and fathers (their male partners) and those in authority in the health sector of the district charged with the responsibility of ensuring provision of health care services for these selected study population.

3.4 Study Unit

Is that part of the targeted population accessible (can be group of individuals or people or households etc.) that has been procedurally (scientifically) selected to represent it and the findings may be generalized to represent the whole targeted population of interest (Dr. Rick Yount, 4th ed. 2006). Data were obtained from male partners (men); their expectant spouses/mothers; key informants such as health workers (In-charges of the selected health

facility and that of the maternity clinic); selected members of the district health team such as DHO and In-charge of MCNH

3.5 Sample size determination

Cooper and Schindler (2000), states that the sample size is the selected element or sub-set of the population that is to be studied.

The sample size for the cross sectional survey was calculated using the Cochran's formula:

$$N = \frac{Z^2 * p(1-p)}{d^2}$$

Where;

n = Sample Size

z = Standard normal value corresponding to 95% confidence interval = 1.96

d = Margin of error 3% = 0.03

p = Expected proportion of male partners tested at skilled ANC, delivery and postnatal clinics from Lira district report in 2010 is used which is 10%.

q = 1-p = 1-0.1 = 0.9

n= 1.96^2*0.1*0.9/0.03

n=3.84*0.1*0.9/0.0009

n=384+10% NR= 422

The computed figure 384 was adjusted by 10% for inconsistencies and to cater for non-response arriving at a sample size of 422.

This study employed simple random sampling technique where all potential respondents had an equal and independent chance of being selected., Purposive sampling technique was used

to select KIs from which information health systems factors as well as nature of male partner participation in skilled ANC, delivery and postnatal care services was obtained.

3.6 Data collection method and tools

3.6.1 Variables

Active male partner participation as the dependent variable was measured by two attributes: the first was the nature that would manifest as the kind of support examples would include but not limited to financial support, escorting the spouse to receive services, etc. and the second attribute measured was level of male partner participation that included 4 levels with best level taken as level 4 as described below

Level of participation	**Manifestations**
Level 1	No financial support and didn't accompany spouse
Level 2	Also called male involvement includes Physical involvement – only escorted the spouse for skilled maternal care services but he didn't participate
Level 3	Gave financial support and didn't accompany spouse
Level 4	Known as active male partner participation i. Physical involvement – escorting the spouse for skilled care, giving financial support, transport support ii. Domestic chore reduction and support iii. Active decision making in all stages of skilled care iv. Taking different roles as shared responsibility

Table 1: Parameters used to categorize the levels of active male partner participation

The independent variable was factors that were related to the observed level and nature of participation that included men's income status; marriage relationship type; whether couples were living together or not; who was the decision maker concerning family health issues and lastly the male partner level of knowledge of the spouses/mothers' dates for appointment - other factors included demographic and ecological factors.

3.7 Study Instruments

Quantitative data was collected using semi-structured questionnaire while qualitative data from the key informants (KIs) was collected using focus group discussions (FGDs) and KI in-depth interviews using the interview guide coupled with probing questions.

3.8 Plans for Data Analysis and Presentation of Results

3.8.1 Data Analysis

Qualitative Data

Qualitative data were collected using , audio-machine recorded qualitative data obtained during the in-depth interviews with the KIs, was all transcribed, and analysed using themes and sub-themes and the during the analyses researcher traced the relationships between the variables, and interpreted these information and their impact in skilled ANC, delivery and postnatal care services. In addition, the researcher crossed examined the findings of this study with the other earlier findings found in reviewed literatures in order to identify if and whether there were any new changes in the level and nature of male partner participation in skilled ANC, delivery and postnatal care services and if the related factors to the observed level and nature are any different from those mentioned in the earlier literature reviewed and any changes in perceptions and attitudes.

3.8.2 Quantitative data

Quantitative data were analysed using statistical package for social sciences (SPSS) software, version 21, semi-structured questionnaire were all coded to ease data entry into the computer and after all the data was entered, the researcher ran cleaning frequencies to ensure data entered made sense as expected in accordance to the study questions and objectives.

3.8 Data management and processing

3.8.1 Qualitative Data

All qualitative data collected through FGDs and in-depth KI interviews were all audio-machine taped recorded, transcribed, and analysed in themes and sub-themes, to identify the relationship between the variables.

3.8.2 Quantitative Data

All quantitative data collected through semi-structured questionnaires were analysed using statistical package for social sciences (SPSS) software, version 21 semi-structured questionnaire were all coded to ease data entry into the computer and after all the data was entered, the researcher ran cleaning frequencies to ensure data entered made sense as expected in accordance to the study questions and objectives. Descriptive statistics was used and hypotheses were tested using the inferential statistics of Pearson product to find out the relationship between the independent and dependent variables.

3.8.3 Data processing

The researcher took notes during the group discussions in English. A simultaneous translation from Luo/Kiswahili into English was provided by an experienced Lango/Kiswahili translator. The translator originated from within the study area which was an additional advantage. The note taker wrote word-for-word all the comments which were raised by the participants as well as the facilitator. As a back-up, the group discussions were recorded with a digital voice recorder (Philips, model LFH0635). The notes were, however, quite complete. The translator proficiently documented all answers and comments raised by the participants as well as the facilitator word-for-word in English. The group discussions generally lasted between two and three hours with the exception of one FGD which lasted for four hours. Before the interview process started, the audio recording machine was tested to ensure it worked well, to avoid the researcher losing data. During the time of the interviews all data was captured and a note book was used to take notes of key points mentioned during interview process by some

participants. After the interview process was completed, the researcher tried to play the audio recording to be sure the recording was done successful and all the recording radio machines were kept very well.

Data processing was done through transcription of the audio recording by a trained person, the researcher then read the transcribed piece of work for at least five times in order to generate themes that was analyzed. The audio recording was transferred to a CD recorder for submission to the faculty of health sciences of Uganda martyrs University as part of the partial fulfillment for the award of degree of master of public health in health promotion.

3.9 Quality Control

Validity and reliability are the two important concepts in the acceptability of the use of an instrument for research purposes (Amin, 2005. Pp. 284). In order to reduce the possibility of getting the answer wrong, attention needs to be paid to the two particular areas of research design (Saunders et al., 2003).

Conventional measures of quality in quantitative research like validity, reliability and generalizability are seen, by some researchers, as inappropriate to use for qualitative research (Pilnick and Swift, 2011). Concepts like credibility, dependability and transferability have been proposed to describe trustworthiness in qualitative research (Creswell, 2007; Lincoln & Guba, 1985). However, within qualitative content analysis, the terms validity, reliability and generalizability are still used (Graneheim and Lundman, 2004; Shields and King, 2001). Validity and generalisability were considered, following Pilnick and Swift (2011).

3.9.1 Reliability

The researcher adopted the test-retest method as propounded by Charles (1995) cited in Admin, 2005, who argued that consistency with which questionnaires (test) items are answered or individual's scores remain relatively the same can be determined through the test-retest method at two different times.

3.9.2 Validity

Validity refers to the "issue of whether the researcher's accounts truly reflect what actually happened" (Pilnick and Swift, 2011; p. 210). Since replication is not possible in social research, another form of validity, mainly triangulation and respondent validation, is used (Pilnick and Swift, 2011). Triangulation is an "attempt to replicate research within the same settings, rather than across different ones" Pilnick and Swift, (2011; p. 210).

In qualitative content analysis it is important that the formulated categories are empirically and conceptually grounded. A clear description of the participants' selection, characteristics and the context is needed to facilitate transferability. This is also called external validity (Elo and Kyngäs, 2008). For this purpose, socio-demographic characteristics of participants were noted. Descriptive analysis was used for quantitative data

The principal investigator supervised the research assistants. Each questionnaire was given interviewers initial and code that facilitated cross checking of the completed questionnaire. The completed questionnaires were checked for completeness and any inconsistencies on the field. Data was doubly entered into ATLAS qualitative data analysis package on the same day. The audio recordings from focus group discussions was played back to ensure complete recording of the whole discussion. The tapes were labelled with the group name and date. Transcription of the recorded discussions was done as soon as possible after the discussion.

For qualitative data;

Transferability

The focus group discussion and key information informants' tools should be able to generate similar findings when used to collect data for a similar study in another geographical area or in a later date.

Conformability

The focus group discussion and key information informants' tools were subjected to guidelines of collecting qualitative data. During focus group discussion, the study a

moderator and a secretary. The secretary noted everything that the respondents were urging out so that no useful information was left out during data collection

3.9.3 Inclusion Criteria

- For a key informant to qualify to participate in the study one had to have worked at the health facility for at least 1 year or more.
- The women must have been those who were expecting and are receiving antenatal care from one of the selected health facility.
- The men must have been those whose wives were currently expecting and had started attending Antenatal care in any of the selected health facility

3.9.4 Exclusion Criteria

- The selected staff in any of those relevant positions must be new or had not worked for at least one year so far was excluded from the study.
- Self-exclusion was allowed from potential participants themselves.

3.10 Ethical Considerations

Approvals

Before the study began, approval and permission was obtained from the ethical advisory board at Uganda Martyrs University School of Health Sciences, School of Public Health Higher Degrees, Research and Ethics Committee and registered by the Uganda National Council for Science and Technology. The University was required to issue authorization letter introducing the researcher to lira district health office (DHTs).

- All interviews were tape-recorded after seeking and gaining permission of the participants.
- The researcher and his team was explicitly introduced formally as such to all community members at the beginning of the study period and in all selected health facilities so that all people are made aware and made to understand that their health facility and their community is being studied for academic purposes.

Prior adequate awareness created among the potential respondents about the study.

During the study the researcher ensured that the respondents are informed in details of the purpose for which the study is being undertaken and it's upon this that their voluntary informed consent was obtained.

Voluntary written informed Consent

A written consent instruction was obtained from individuals who participated in the study, interview was a must requirement. Every discussant had the right to refuse or decline to participate in the interview, or refuse to answer certain specific or sensitive questions after consenting or assenting to participate in the study and the study prefers all the discussants to be 18 years and above and the researcher also made consideration for young parents below 18 years to ensure they are also able to participate so that their voices are also heard in this study

Exculpatory language

Informed consent form must not contain any exculpatory language by which a participant waives nay legal rights or releases the investigator or sponsor from liability for any kind of negligence

Voluntariness to participation

The participant's consent to participate in the study was totally voluntary, free of coercion or inflated promise of benefits from participation. Care was taken and consent forms were administered by individuals who didn't hold any kind of authority over the potential participants.

Confidentiality

Subject to the requirements of legislation, including the data, protection Act, and information obtained from and about participants is confidential unless otherwise agreed in advance. Discussants' names or other identifying information was not recorded on the interview scripts; the interviewers ensured there was no way to link a specific script to a specific

discussant in any of the group. The interviewers ensured they did not discuss the participants' answers with anyone else. Completed recorded transcribed scripts/forms were kept in appropriate storage inaccessible to anyone else unauthorized to have access to them.

All collected data was secured under password-protected files that were accessible only to the researcher and his research team and Pseudonyms was used in reporting in order to ensure confidentiality.

Approval from head of health sector in the district and head of health facility

Competence

All participants must be competent enough in their right mind set to give consent. In case the potential participant is not competent due to mental status, diseases or emergency, a designated surrogate may provide consent if it is in the participant's best interest to participate.

3.11 Limitation of the study (to achieve the methodology chosen)

Unwillingness from some potential respondents

There was some unwillingness among some potential respondents to participate in the survey especially in answering the questionnaires and returning them, others demanded for financial gains during the process of gathering information thus leading to information bias from those who were interviewed. This was however minimized through explanation of the aims and purpose of the study to the respondents.

Men's claimed busy schedules

This couldn't allow some potential respondents to participate in this survey therefore the researcher missed to hear their opinions in regards to the set objectives, so some creditable information must have been missed to add to what the researcher managed to gather from other respondents. The data was collected throughout the 7 days of the week (Monday to Sunday) between 8.00 am to 6.00 pm. Therefore the men who go for work far from their homes who were presumed to be available at home late in the evening and on Saturday or

Sundays were missed out. However the researcher minimized this by communicating to the local leaders of the villages nearby the selected health facilities prior to the planned visit such that they guide us on the timing of our data collection an appropriate time when most of the men are likely to be home.

Some dilution of information during transcription of data collected during the KIs and FGDs

The FGD and KI analysed information had to be translated into English first, which could have diluted the original richness of the data including possible loss of information. This was minimized by ensuring that translation was done by experienced data collectors as soon as each interview was accomplished.

3.12 Plans for Dissemination of Results

The findings from this study are proposed to be disseminated to all the key stake holders in MNCH, SRHS and to other gender programmes implementers and they will includes: -

- Uganda Martyrs University faculty of Health sciences/library;
- Lira district Health Office, to DHO's office or district in-charge of MNCH
- To the ministry of higher education/ministry of science and technology plus a manuscript

CHAPTER FOUR

ANALYSIS, INTERPRETATION AND PRESENTATION OF THE FINDINGS

4.0 Introduction

This chapter presents the findings in line with the three objectives of study: - the nature, level and related factors to active male partner participation in skilled maternal care services as presented below and data is presented in form of text and tables.

4.1 Nature of active male partner participation in maternal care services

4.1.1 Background characteristics that may influence active nature/level of active male partner participation in skilled maternal care services

Table 2 show demographic characteristics of the respondents

Characteristics	Frequency	Percent (%)
Age in years		
20-24	80	22.3%
25-30	20	5.6%
31-35	158	44.1%
36-40	100	27.9%
>40		
Gender		
Male	208	58.1%
Female	150	41.9%
Total	**358**	
Residence		
Rural	276	77.1%
Urban	82	22.9%
Total	358	
Religious affiliation		
Christian	286	79.9%
Muslim	36	10.1%
Others	36	10.1%
Total	**358**	
Education levels		
No education	98	28.0%
Primary	152	43.0%
Secondary	72	20.1%
Tertiary	32	8.9%
Graduate and above	4	1.1%
Total	**358**	
Respondent's employment status		
Public servant	7	2.0%
Private sectors	28	7.8%
Farmers	286	79.9%
Business operation	37	10.3%
Total	**358**	

Source: Primary data, 2018

Table 1: Shows the demographic characteristics of the respondents

Table. 2 illustrates 358 respondents took part and completed the survey. Majority were between the age of 31-35, of which 208 (58.1%) of the respondents were male partners and 150 (41.9%) were women. The religion distribution of the respondents indicates majority being Catholics 286 (79.9%). 152 (43.0%) of the respondents (both men and women) had primary level education, 98 (28.0%) had no education at all. In an attempt to ascertain the

respondent's employment status, the majority 286 (79.9%) of the interviewed participants reported to be farmers while few were in public or private sectors

4.1.2 Nature of active male partner participation in skilled maternal care services

Nature of male participation was examined using a number of parameters that involved physical involvement, decision making and shared responsibility in all processes regarding skilled care and domestic chores. Male partners were observed to participate in one or more of the parameters as presented in table 3

Characteristics	**Frequency**	**Percent (%)**
Parameter	**Respondents' responses Y (%) or N (%)**	
	Yes	**No**
Provides financial support to partner as transport to attend ANC, delivery & postnatal	58(16.2%)	300(83.8%)
Discusses with partner information or interventions given in ANC, delivery & postnatal (Decision making)	22(6.0%)	336(94.0%)
Voluntarily take time to find out what goes on in ANC, delivery & postnatal clinics(shared responsibility)	61(29.3%)	147(71.0%)
Been with her during labour	90(25.0%)	118(56.7%)
Been with her in group health discussion	46(22.1%)	162 (77.88%)

Source: Primary data, 2018

Table 2: Nature of male partner's active participation in skilled maternal care services

Table: 3 The nature of male partner participation in skilled Antenatal care, delivery and postnatal care services was assessed using the variables shown in the table 3 above: Only 58 (16.2%) of the 208 men reported provided financial support for their spouses to attend ANC, delivery & postnatal care services in form of transport, 22 (6.0%) male respondents reported not discussing with partner any related information or interventions given in ANC, delivery & postnatal care services.61 (29.3%)of the male respondents reported not taking time to know from their spouses what took place at the health facility. Only 25.0% responses indicated that they had been with their spouses during the labour times, and only 22.1% also reported that they had been with their spouses for health group discussion.

However, all FGDs perceived nature of male participation to be like men escorting their spouses to health facilities as active male participation in skilled ANC, delivery and postnatal care services. This is irrespective of whether the men were destined to receive or not to receive any service at the health facility. Both male and female FGDs perceived active male participation as mere men and their spouse taking HIV blood testing together. This quote illustrates a response that was given by one of the men during the FGD;

> It is only when both partners take an HIV test together to know their status as a couple is enough male participation and of course if after one of you is found to be HIV positive like your wife then the husband protects himself, provides support in terms of escorting the wife to the hospital, providing for the needs of wife and child as well as any other necessary material support. (FGD, male partners, Lira) at 15:37 hours, 14th/12/2017.

However, "men were concerned that coercive procedures existed at health facilities. Such procedures were reportedly intended to force men escort their spouses to health facilities for HIV blood testing. Among them, health workers the nurses in particular were literally reported to chase away our women whenever they were not accompanied by her spouse".

Some men in the FGD were forced to speak out to clarify…"despite the fact that some women failed to receive a service in case the husband refused to accompany them, forceful procedures by the health staffs the nurses had an advantage because some of them who laboured to accompany their spouses have become informative about active male participation in skilled ANC, delivery and postnatal care services".

A male discussant in Lira said; "For me I knew about our participation when my wife was pregnant and was chased away from the health facility because I did not escort her. She only received care when I went back to health facility with her".

Even though not mentioned by the service providers, the reported coercion at health facilities implied that health workers partially understood what active male participation in maternal care services simply as men escorting their women for HIV blood testing only as always emphasized to women at skilled ANC that they must come with their husbands to test for HIV, little is told to the expectant spouses/mothers especially in regards to other services.

4.1.2 Level of active male partner participation in skilled maternal care services.

The key attributes/parameters used to measure objective 2 included 4 levels with the best level taken as level 4 as stated below; -

Level	Descriptions
Level 1:	No financial support and didn't accompany spouse
Level 2:	Male Involvement: Male partner only escorted his spouse for skilled ANC, delivery or postnatal care services
Level 3:	Gave financial support for transportation but didn't accompany spouse
Level 4:	Known as active male partner participation: Male partner accompanied spouse-Physical involvement of escorting, gave financial support, domestic chore reduction and support, active decision making in all stages of skilled maternal care services and takes different roles as shared responsibility

Therefore, the participants were asked probing questions directed to find out whether a particular 'A' is in any of the different levels and he/she would be graded accordingly, refer to the result findings tables below;

Characteristics	Frequency	Percent (%)
Family income earners		
Only husband	157	44.0%
Only wife	79	22.0%
Both husband & wife	98	28.0%
None of them	24	6.7%
Total	358	100.0%
Men's income status		
Regular	67	18.7%
Not regular	291	81.3%
Total	358	100.0%
Marriage relationship		
Monogamous	251	70.1%
Polygamous	34	9.5%
Co-habiting	47	13.1%
Pregnant living with parents	26	7.3%
Total	358	100.0%
Couple living together		
Yes	332	92.7%
No	26	7.3%
Total	358	100.0%
Decision maker concerning health issues in the home		
The woman herself	298	83.2%
Her husband	22	6.1%
Jointly (woman & husband)	38	10.6%
Total	358	100.0%
Item (variables)	Respondents' responses Y (%) or N (%)	
	Yes (%)	No (%)
Ever attended skilled ANC, delivery & postnatal care services with partner	71(19.8%)	287(80.2%)
Knows partner's ANC, delivery & postnatal appointments	41(11.5%)	317(88.5%)

Source: Primary data, 2018

Table 3: Characteristics examined for possible influence on the level of male partner's active participation in skilled maternal care services

Table 4: illustrates that 358 respondents took part and completed the survey. Pertaining family income earnings, 157 (44.0%) of those interviewed reported the husband as the main income earners but which income is not regularly earned. 98 (28.0%) reported the wife and husband earning together while 79 (22.0%) reported only women as main income earners in a home.

The majority of the respondents 251 (70.1%) reported living in a monogamous marriage, followed by co-habiting at 47 (13.1%) and of which 332 (92.7%) of the couples were living together. Pertaining decision making concerning family health issues, 298 (83.2%) of the women reported taking lead in decision making, and remarkably a smaller number of the interviewed reported making decisions jointly with their husbands 38 (10.6%) and it was clear that fewer male partners today take lead in decision making in homes when it comes to family health 22 (6.1%).

The study also revealed that the proportion of male partners who have ever attended skilled ANC, delivery or postnatal care services with their spouses was relatively low at 287 (80.2%) compared to those who have attended 71 (19.8%).

And this was clearly evidenced by the fact that very few male partners knew their spouses' clinic appointment dates for skilled ANC, expected date of delivery and postnatal care check-ups dates, 317 (88.5%) couldn't mention any of these dates while only 41 (11.5%) of the male partners knew the dates.

Therefore, because of the low proportions of male partners who ever attended and knew some of the activities that take place in skilled ANC the researcher went ahead to find out more regarding male partner's Knowledge in skilled ANC, delivery and postnatal activities in a way to gauge the levels of their participation in skilled ANC, delivery and postnatal care services and their responses are presented below in a graph. The survey shown that most men out there are known to a good extent.

A total of 150 expectant spouses/mothers were interviewed at the health facility when they were receiving health care services at either skilled ANC, delivery or postnatal clinics, took note of which visit she had come for either first, second, third or fourth skilled ANC visit and these were the findings; -

Parameters	No. of women in attendance	No. of male partners in attendance	1st skilled ANC visit	2nd skilled ANC visit	3rd skilled ANC visit	4th skilled ANC visit
Level 1	27 (18.0%)	7 (12.1%)				
Level 2	91 (60.7%)	33 (57%)				
Level 3	19 (12.7%)	5 (8.6%)				
Level 4	13 (8.7%)	13 (22.0%)	✓ majority			
	150	58				

Source: Primary data, 2018

Table 4: Level of male partner's active participation in skilled maternal child health care services.

The study established that the majority of expectant mothers 91 (60.7%) reported being at level 2 of MI; however most men 33 (57%) who were found at the health facilities had accompanied their spouses for her first skilled ANC visit and primarily to test for HIV since its mandatory for all men whose spouses are expectant.

One of the Community Health Workers (CHW) told us that "…this big number of men seen in the first visit tend to disappear in the subsequent 3 remaining visit meaning the big number of men is forced to come just because the health workers tell their wives that if they don't come with them husband, they won't work on them in skilled ANC and yet men still few HIV testing"

Parameters	No. of women in attendance	No. of male partners in attendance
Level 1	5 (11.4%)	0
Level 2	21 (47.7%)	4 (57.1%)
Level 3	11 (25.0%)	1 (9.1%)
Level 4	7 (16.0%)	2 (40.0%)
	44	7

Source: Primary data, 2018

Table 5: Male partner's levels of attendance in skilled delivery care services

The study established that there were more women than men and the majority of expectant mothers 21 (47.7%) who were found receiving skilled delivery care services at selected health facilities reported not receiving any financial support from their spouses as labour pain set on, and were just escorted by their spouses to the health facility, they also reported saving

no money to cater for delivery and women whose male partners had accompanied them were mainly those from urban setting.

Indicators	No. of women in attendance	No. of male partners in attendance
Level 1	32 (47.8%)	0
Level 2	13 (19.4%)	5 (7.5%)
Level 3	12 (18.0%)	0
Level 4	10 (15.0%)	4 (6.0%)
	67	9

Source: Primary data, 2018

Table 6: Male partner's level of active participation in skilled maternal child health care services

The study established that there were more women in attendance than the men in postnatal care clinic, and majority 47.8% reported not been given any kind of financial support from their husbands

Different factors influencing the level and nature of male partner's active participation in skilled maternal child health care services

Key socio-demographic and economic variables such as male partner's and spouse's age, residence status, level of education, employment status/occupation, men's income status, marriage type examined in this study, as well as the level of knowledge regarding skilled ANC, delivery and postnatal care services to establish if it could affect male partner's level/nature of participation in enhancing their spouse's access of skilled ANC, delivery and postnatal care services.

Result Analysis

Factors	Response	frequency	Percentages	F-test Value	P-Value
Age	<30	100	20%	5.34	0.012
	31>	258	80%		
Asked whether it has influence or not on AMPP	Yes	264	74%		
	No	94	26%		
Religion affiliation	Christians (Catholic & Protestant)	286	40%	1.05	0.270
	Muslim	36	10.1%		
	Others	36	10.1%		
Asked whether it has influence or not on AMPP	Yes	94	26%		
	No	264	74%		

Source: Primary data, 2018

Table 7: Significant relationship between the age, religion affiliation on the level and nature of male partner's active participation in maternal child health care services.

The findings shown that, there is a mean difference between age groups <30 and 31> on the nature and level/nature of active male participation in maternal health care services. A F-value (5.34>3.23) shows that there is mean difference between age brackets (<30 and 31>) A p-value (0.012<0.05) gives us evidence that there is a significant relationship between age and level/nature of active male participation in maternal health care services.

Using a one way ANOVA test, the findings from the study show that there is no mean difference between religion affiliations (catholic, protestant, Muslim and others). F-value (1.05<3.23) shows that there is no mean difference between the groups and nature/active male partner participation in maternal health care services. A p-value (0.270>0.05) gives us evidence that there is no significant relationship between religion affiliation and nature/active male partner participation in maternal health care services.

Factors	Response	Frequency	Percentages	F-test value	P=Value
Residence	Rural	N=276	77.1%	8.2	0.003
	Urban	N=82	22.9%		
Asked whether it has influence or not	Yes	241	67%		
	No	117	33%		

Source: Primary data, 2018

Table 8: Relationship between residence type and the level/nature of active male partner participation in supporting their spouse's access to skilled maternal care services

The findings from the study show that there is a mean difference between rural and urban men in terms of level/nature of active male participation in maternal health services. A F-value (8.2>3.2) gives us evidence. A p-value of (0.003<0.05) gives us evidence that there is a statistical significant relationship between residence type and level/nature of active male participation in maternal health service.

Factors	Response	Frequency	Percentages	F-test value	P-Value
Level of education	No education	98	28%	6.89	0.014
	Primary	152	43%		
	Secondary	72	20.1%		
	Tertiary	36	10%		
Asked whether it has influence or not	Yes	171	48%		
	No	187	52%		
Employment status/Occupation	Employed	72	20.1%	4.5	0.000
	Unemployed	286	80.0%		
Asked whether it has influence or not	Yes	195	54%		
	No	163	46%		

Source: Primary data, 2018

Table 9: Relationship between level of education, employment type and the level/nature of active male partner participation the spouse's access to skilled maternal care services

The findings from the study show that there is a mean difference between levels of education amongst men in active male participation in maternal health services. A F-value of

(6.89>3.23) gives us evidence of rejecting the null hypothesis that there is no significant mean difference between level of education and men participating in maternal health services. A P-value (0.014) shows that there is a significant relationship between level of education and level/nature of active male participation in maternal health services.

The findings from the study show that there is a mean difference between employment status and a nature/level of active male participation in maternal health services, the F-value (4.5>3.23) gives us evidence that there is a mean difference between employment status groups. A p-value of (0.000<0.05) shows that there is statistical significant relationship between employment status and level/nature of active male partner participation in maternal health services.

Factors	Response	Frequency	Percentages	F-test value	P-value
Men's income status	Regular	67	18.7%	7.98	0. 001
	Irregular	291	81.3%		
Asked whether it has influence or not	Yes	138	38%		
	No	220	62%		

Source: Primary data, 2018

Table 10: Relationship between men's income status and the level/nature of active male partner participation in their spouse's access to skilled maternal care services

The findings from the study show that there is mean difference between men's income status and level/nature of active male participation in maternal health services. F-value (7.98>3.23) shows that there is significant mean difference between Regular income earners and irregular income earners. A p-value (0.001<0.05) shows that there is significant relationship between Men's income status and level/nature of active male participation in maternal health services.

Factors	Response	Frequency	Percentages	F-test value	P-Value
Marriage type	Monogamous	251	70.1%	10.56	0.024
	Polygamous	34	9.5%		
	Co-habiting	47	13.1%		
	Pregnant living with parents	26	7.3%		
Asked whether it has influence or not	Yes	277	77%		
	No	81	23%		

Source: Primary data, 2018

Table 11: Relationship between marriage type and the level/nature of male partner's active participation in skilled maternal child health care services.

The findings from the study show that there is mean difference between marriage type categories and level/nature of male participation in maternal health services. F-value of (10.56>3.23) gives us evidence that there is mean difference amongst monogamous, polygamous, cohabiting and women pregnant living with their parents. A p-value (0.024<.0.05) shows that there is significant relationship between marriage type and the level/nature of active male partners participating in maternal health services.

Factors	Frequency	Percentages
Men's willingness	Maternal health Services are free (N=14)	6.7%
	Couples given much time (N=17)	8.2%
	I love being with my wife (N=12)	6.0%
	Personal responsibility (N=39)	18.8%
	Invitation letter from H/W (N=8)	4.0%
	Perceived complication with wife (N=53)	25.5%
	Women's failure to disclose important information (N=19)	9.1%
	To get first-hand information (N=33)	16.0%
	Lack of trust in what women report (N=13)	6.3%
	Total	**100%**

Source: Primary data, 2018

Table 12: Male partner's reasons for willingness to actively participate in their spouse's skilled maternal child health care services

25.5% of the respondents said that perceived complication with wife is the main factor that stimulates them to actively participate in maternal health services. 18.8% of the respondents said that it was personal responsibility, 16% of the respondents said that to get first-hand information, 9.1% of the respondents said that women failure to disclose important information, 8.2% of the respondents said that couples being given much time at the health centres, 6.7% of the respondents said that maternal health services are free, 6.3% of the respondents said that lack of trust in what women report, 6% of the respondents said that they loved being with their wives, 4% said that invitation letter from the health centre was a factor that stimulated them to actively participate in maternal health services.

Factors	Frequency	Percentages
Men's Non-willingness	Men have busy schedules as bread earners (N=198)	15%
	ANC is a woman responsibility (N=180)	14%
	Men's fear for HIV testing (N=199)	15%
	Generally nurses don't look at men as important (N=161)	12%
	Men are left un attended to by nurses (N=204)	16%
	Wastes a lot of time (N=187)	14%
	H/W don't invite men (N=54)	4%
	H/facilities are very far (N=89)	6.7%
	Messages passed are mainly focused on women (N=42)	3%
	Total	100%

Source: Primary data, 2018

Table 13: Male partner's reasons for Non-willingness to actively participate in their spouse's skilled maternal child health care services

The findings from the study show that 16% of the respondents said that men are left out unattended to by nurses at maternal health centres, 15% of the respondents said that men have busy schedules as bread earners and fear for HIV testing respectively. 14% of the respondents said that maternal health care services is a woman's responsibility and a lot of time is wasted at the maternal health care centres, 12% of the respondents said that the nurses generally do not see men as important in maternal health care services, 6.7% of the respondents said that

maternal health care centres are far, 4% of the respondents said that health workers do not invite men to maternal health care centres, 3% of the respondents said that messages passed are mainly women centred. The findings show that the main reason for non-willingness of men to actively participate in maternal health care services is men being unattended to by nurses even when they escort their wives for maternal health care centres.

Using qualitative approach, these were the responses from the community;

In one male partner FGD however respondents said that "...Most times I do not accompany my wife to ANC check-ups and had no special reason".

This was further supported by qualitative data from one of the female FGDs where mother's responses indicated males who attended with them ANC services became more knowledgeable about maternal health and became more sportive to their spouses during pregnancy.

> One female respondent lamented "….From the time my husband started getting some time to come with me to the clinic, he has changed a lot. He is more concerned about my health and even the way I eat and work"
> Qualitative data from one of the KI is in support. One of the mid-wife who was found on duty echoed that "...there is really good benefit for the males and their spouses when they come here as a couple…we have actually also found it very easy to work on them…." (A mid-wife who was on duty in maternity ward at the time of this data collection, 11th.12. 2017)

The other important issue that the study discovered was the different understanding of active male partner participation from the informants and this implies that if the informants have different opinions than it becomes difficult to convince the men because we may be over expecting from men yet they too are confused by these many perceptions. The following are some of the perceptions gathered from the KIs.

Most KIs perceived active male partner participation in skilled ANC, delivery and postnatal care services as the resources that men gave to their spouses at home or health facilities; during antenatal, delivery or postnatal periods. They did appreciate that such provisions were

necessary irrespective of age, education status, socio-economic status, which is illustrated in the following quote:

> "..it is the social, moral, economic and physical support a man offers to the female partner during pregnancy, labour or after delivery, even if they are HIV positive or negative.' (KI, In-charge health center IV, Amach, Lira) 12th, 12, 2017.

Some of the nurse midwives interviewed about their perceptions they felt that since active male partner participation is intended to benefit the wife and their unborn child, active male partner participation had to occur before, during and after the baby's birth. To realize this, they suggested male partner's participation during the child's growth, irrespective of their contributions during the antenatal and delivery periods. They advised men to partake of roles like helping feed the baby when the mother is tired, bathing the baby among other roles.

> "Active male partner participation is when a man prepares for a pregnancy, supports the wife financially and gives her company to the hospital for antenatal visits. Even during delivery, men should provide practical physical and social support to women". (KI, Head of nurses, LRRH) 14th, 12, 2017.
> "…is when men take their female partners to hospital for safe delivery. It also includes men ensuring that children get good health as well as monitor their growth at home". (KI, Head of nurses, LRRH)
> "…is where a couple shares responsibilities during pregnancy and feeding the infant. We need men not only to accompany wives but to have interest in what happens at ANC, like having the HIV test together".(KI, a doctor found in the FP clinic, LRRH). 14th, 12, 2017.

In addition to other KIs who observed that active male partner participation in skilled ANC, delivery and postnatal care services was for the baby's benefit. The interviewed managers from district health office felt strongly that in addition to the targeted babies, it enhances women's decision making. They believed that presence of a man when a spouse was pregnant improved the decision making processes.

> Another doctor in HIV clinic said "...Most women both in urban or rural settings are very poor to meet the demands that come with accessing skilled ANC, delivery and postnatal care services thus have to depend on their men and this is why we advocate for male partners to be supported throughout this is because most women can't take a decision thus rely on their men for decision taking and to avoid conflict since the society knows men as decision makers in homes" (At LRRH a doctor found in the maternity ward, 14th. 12.2017)

Similarly, another doctor acknowledged that;

> "…most African women do not have decisions hence it would be better when a man is round and the fact that most women especially village women are generally economically poor".(At LRRH a doctor found in the maternity ward, 14th. 12.2017)

Similarly from the FGDs male and female FGDs response further show the wives, in some cases, would or could not, make major decisions in their absence of their partners but the presence of the man would fasten their decision as a couple.

Attributes	Frequency	Percentages
Levels of male partner's knowledge in spouse's skilled maternal child health care services	Health education (N=107)	13%
	Weight taking (N=46)	5.5%
	HIV blood testing (N=208)	25%
	Giving medication (N=77)	9%
	Urine testing (N=67)	8%
	Screening for other STIs (N=108)	13%
	Examining women's stomach (N=23)	3%
	Listening to baby's heart sound (N=8)	1%
	Immunisation of baby (N=186)	22%
	Total	100%

Source: Primary data, 2018

Table 14: Male partner's levels of knowledge in their spouse's skilled maternal child health care services.

22% of the respondents said that immunisation of the baby influenced them in actively participating in maternal health services, 13% of the respondents said that health education and screening for other STI's, 25% of the respondents said that HIV blood testing, 9% of the respondents said that receiving medication, 8% of the respondents said urine testing, 3% of the respondents said that examining expectant spouses, 1% of the respondents said that listening to babies heart. The major reason behind males knowledge influence on nature/level of active male participation in maternal health services is HIV blood testing.

Using qualitative approach, these were the responses

During one of the FGD with the men, I asked why HIV testing was the most known activity identified by all of them the 208 who were interviewed and they reported;

> "They called it forced HIV testing, we are forced to test and if you don't test, the nurses won't examine your wife in ANC and she will be sent back home which is the only reason why we are here".
> One of the men stood up and reported that "blood testing which he was referring to HIV testing, is the only message talked about in the health centres and even the commonest on radios, they ignore other things like checking men for and our women only come home

> telling you, you are needed in the health centre to test blood only, nothing else".(A man found at Ogur HC IV whose wife was expecting, 15th. 12.2017)

Men also reported on why examination of women and listening to baby's heart or fatal heart were the least activities identified, they reported "nurses don't allow them to go in the clinical examination room together with their women, so we don't know what is done inside when they are in the clinical examination room"

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

In this chapter, the results are discussed, interpreted, summarized, conclusions and recommendations drawn.

The discussion was done and presented as per the set objectives of the study as below:

1. To assess the different ways/nature of male partners actively participating in skilled maternal health care services.
2. To assess the level of male partner's active participation in skilled maternal care services.
3. To find out the different factors influencing male partner's active participation in skilled maternal care services.

5.1 Discussion

5. 1.1 Nature of active male partner participation in skilled maternal care services

The findings of this study shown that, men involvement was found the commonest practice among male partners by escorting (57%) while AMPP was (22.0%) which is the entry point to active male partner participation characterised by; mere escorting of expectant spouses/mothers to maternal clinics and testing for HIV simply because it is mandatory.

The findings above was supported by qualitative findings where it was reported that both men and women confuse active male participation to male involvement as for both AMPP is merely men and their spouse taking HIV blood test together and of course if after one of you is found to be HIV positive like your wife then the husband protects himself, provides support in terms of escorting the wife to the hospital, providing for the needs of wife and child as well as another necessary material support while others perceived it as the resources that men gave to their spouses at home or health facilities; during antenatal, delivery or

postnatal periods. They did appreciate that such provisions were necessary irrespective of age, education status, and socio-economic status

However, the study found out a mean difference between men's income status and nature of AMPP. A F-value (7.98>3.23) showed that there was a significant mean difference between regular income earners and irregular income earners. The findings of this study established that men's income status have statistical significant relationship (0.001<0.05) on the nature of AMPP in maternal health services hence men's level of income has an influence on nature of actively male participation in maternal health care services in Lira district

A F-value (5.34>3.23) showed that there was a mean difference between age brackets (<30 and 31>) on the nature of active male participation in maternal health care services. Men who were 31> were more likely to actively participate in maternal health care services. The study found that there was a significant relationship between age and nature of active male participation in maternal health care services as shown by a p-value (0.012<0.05).The findings imply that age of men influences them in actively participating in maternal health services in Lira district

The findings from the study show that there was a mean difference between men's levels of education and their nature of participation in maternal health services. A F-value of (6.89>3.23) gave us evidence of rejecting the null hypothesis that there was no significant mean difference between level of education and male participation in maternal health services. A P-value (0.014) showed that there was a significant relationship between level of education and nature of male participation in maternal health services, hence nature of male participation in maternal health care services is influenced of level of education of men in Lira district

The findings shown that there is a mean difference between employment status and nature of male participation in maternal health services at an F-value of 4.5>3.23 gives the evidence. A p-value of (0.000<0.05) shows that there is significant relationship between employment

status and nature of AMPP in maternal health services. Hence from the study, we conclude that employment status of men generally influences them in actively participating in maternal health care services in Lira district

The study revealed that there was a mean difference between residence type (rural and urban) men in terms of their nature of active participation in maternal health services showed by a F-value (8.2>3.2). A p-value of (0.003<0.05) gave us evidence that there was a significant relationship between residence type and nature of active male participation in maternal health services, hence the findings showed that residence type greatly influence nature of active male participation in maternal care services in Lira district.

The findings showed that there was no mean difference between religion affiliations groups and nature of AMPP in maternal health care services showed by a F-value (1.05<3.23). The findings also revealed that there was no significant relationship between religion affiliations (Catholic, protestant, Muslim and others) and nature in maternal health care services as shown by a P-value (0.270>0.05). The findings imply that religion does not significantly affect the nature of active men participation in maternal health care services in Lira district.

The findings of this study agree with (Byamugisha, Tumwine, Semiyaga, and Tylleskar 2010); Kwambai, et al. (2013); Larsson et al. (2010); Nkuoh, et al. (2010); Theuring, et al. (2009) who stated that Men's perceived direct and indirect roles. The direct role most frequently stated was financial support followed respectively by decision-making, responsibility over women's health (Koo, Makin, and Forsyth, 2013a; Kwambai, et al. 2013; Larsson, et al. 2010; Theuring, et al.2009) and help with housework throughout pregnancy (Kwambai, et al. 2013; Nkuoh, et al. 2010)influences the nature of active male partner participation.

The findings further agree with findings according to Aarnio, Aarnio, Olsson, Chimbiri and Kulmala, (2009), where indirect support through improvement of communication between

couples and faithfulness (marriage type) during pregnancy and support to HIV-positive women and here Aarnio, et al. (2009) also observed that financial support was stated

The findings further agree with Koo et al. (2013a); Duff et al. (2012); Byamugisha, et al. (2010); Larsson, et al. (2010); Nkuoh, et al. (2010); Orne-Gliemann, et al. (2010); Reece et al. (2010), who stated that lack of transport (Tweheyo, et al. 2010), Other reasons included the inability to afford transportation particularly for two people, the need to pay for HIV testing (Duff et al. 2012), pay for care and drugs (Larsson et al. 2010; Reece et al. 2010), pay illegal extra charges (Larsson et al. 2010; Orne-Gliemann, et al. 2010; Reece et al. 2010), and financial conflicts with other urgent household needs (Duff, et al. 2012). As some of the reasons that stop men from accompanying their spouses for antenatal check-up sand this according to the authors they cannot afford to attend antenatal care with their spouses.

The findings further agreed with Maman et al. (2011) also noted that financial provision for the expectant spouses and for nursing mothers and supporting the wives in jointly attending to all the four ANC visits and adhering to the PMTCT of HIV programs and midwives also emphasized the male partner's role as a provider who makes it possible for their spouses to reach health facilities have all been considered as shared responsibilities and is a male partner's mean for direct active participation in skilled Antenatal care and in other sexual and reproductive health services.

Most men also have for long reported believing that their main role was that of a breadwinner (Larsson et al. 2010; Musheke, Bond and Merten (2013) and provider of money for health expenses, ANC/PMTCT clinic fees, food and family well-being (Larsson, et al. 2010; Nkuoh et al. 2010). Nevertheless, the men´s role of guaranteeing family income and having to work is often used as an excuse to not accompany their wives to ANC/ PMTCT clinics (Kwambai, et al. 2013; Larsson, et al. 2010; Musheke, et al. 2013). According to some men's statements, as part of their responsibility (Aarnio, et al. 2009 and Theuring, et al. 2009) and in spite of their awareness of women's financial dependence, they assume that women need their

permission to go to ANC/PMTCT sessions because only male partners can decide which clinic to attend and which ANC/PMTCT care they can afford (Kwambai, et al. 2013). Other men perceive that they have to persuade women and sometimes obligate them to attend ANC/PMTCT clinics or see a traditional birth attendant in reaction to women's careless health conduct, ignorance or laziness (Kwambai, et al. 2013).

The above findings agrees with the findings of Idris, et al.(2006) Kadune State in Nigeria established that employment status and income status of husbands was an important determinant of the place of delivery as wives of employed husbands delivered at the hospital and generate influences the nature of male partner participation.

The findings further agreed with according to (Nkuoh, et al, 2010; Falnes, et al, 2011; and Larsson, et al, 2010) most expectant mothers complained of their male partners' unsupportiveness to ensure they uptake of Antenatal care services and other reproductive health care services and adhere to all the medical instructions told to them the medical doctors and Wachira, et.al. (2012) also confirmed this in their study.

Another finding from this study found out that 94.0% 336 of the respondents reported not discussing with either partners information or interventions given in skilled ANC, delivery and postnatal care services.

Also the other finding revealed that most male partners 71.0% 147 of the 208 male partners interviewed reported not voluntarily taking time to finding out from their expectant spouse/mothers what exactly goes on in skilled ANC, delivery and postnatal care services and this can be attributed to the observed level of male partners participation as found to be low.

The finding from this study also revealed that most male partners 56.7% 118 of the 208 male respondents never accompanied their expectant spouses/mothers in their current or previous pregnancy in skilled ANC, delivery and postnatal care services.

And finally the study also found out that most male partner 77.88% 162 reported not ever holding a group health discussion together with their expectant spouses/mothers.

The findings agreed to (Aluisio, et al. 2010; Nkuoh, et al. 2010; Tweheyo, et al. 2010; Mohlala, et al. 2011; and Koo, et al. 2013a) earlier findings that male partner's attendance in skilled Antenatal clinic with his pregnant spouse, for different reasons, has been for many times considered as providing a venue for male active participation like accompanying expectant spouses in skilled ANC clinic and by taking part in health education and counselling and testing for HIV and his acceptance for HIV screening have been considered forms of male partner participation in skilled ANC services and more so take on the shared responsibilities that comes with the different advices from the technical terms providing the health services. Gilles et al. (2011) observed that encouragement and reminding their spouses of laboratory monitoring and reminding of skilled Antenatal care appointments as observed by (Maman, et al. 2011; Kalembo, et al. 2013 and Kwambai, et al. 2013) while Peltzer, et al. (2010) observed that reminding their spouses about their medical treatment regimens and (Kasenga, et al. 2010; Kalembo, et al. 2013; and Kwambai, et al. 2013) also concluded that reminding their spouses about their hospital delivery which shows how shared responsibilities are being taken by the couple.

According to (Auvinen, 2014; Mohlala, et al. 2011 and Kalembo, et al. 2013) found that practicing a safe sexual life was commonly viewed to mean that a male partner is faithful to his spouse and meant that a male partner uses condoms in sexual intercourse in case there is a transmission risk which is a strong evidence to show shared responsibilities among the couples.

Maman, et al. (2011) also found that financial provision for expectant spouses or nursing mothers to support their wives to attend all the four ANC visits and this was also emphasized by the midwives that the male partner's role as a provider makes it possible for their spouses to reach health facilities which is considered as shared responsibilities and this is a male partner's mean for direct active participation in skilled MNCH and in other sexual and reproductive health services. Therefore, Mburu, et.al. (2012) observed that among other

factors, men's uncommon behaviours in ANC programs contribute to poor health care services outcomes which agrees with the findings from a study by Nompumelelo, et al. (2017) observed that, adherence to medical guidelines/standards is still a challenge to most women in patriarchal societies simply because most men don't actually actively share responsibilities.

5.1.2 Male partner's level of participation in skilled maternal care services

The findings of the study showed that men who have ever gotten involved/attended skilled ANC, delivery & postnatal care services with partner were 19.8%. 80.2% said that they had not attended skilled, ANC, delivery & postnatal care services with their partner. The findings imply that active partner's level of participation in maternal health care services is low in Lira district at 19.8%

The findings of the study showed that there was a mean difference between men's income status and men's levels of active participation showed by a F-value (7.98>3.23).A P-value (0.001<0.05) showed that there was significant relationship between men's income status and men's levels of active participation in maternal health services. Meaning a male partner with regular income status were more likely to actively participate in the maternal health care services of their spouses and children simply because they have finances to help drive their level of participation than a male partner with irregular income status.

A F-value (5.34>3.23) showed that there was a mean difference between age brackets (<30 and 31>) on the level of active male participation in maternal health care. There was a significant relationship between men's age and their levels of active participation in maternal health care services as shown by A p-value (0.012<0.05). This implies that men's age influences the level of active male partner participation in maternal health care services in Lira district

The study revealed that there was a mean difference between rural and urban residence men and their levels of active participation in maternal health services showed by a F-value

(8.2>3.23). A p-value of (0.003<0.05) gave us evidence that there was a significant relationship between residence type and level of active participation in maternal health services, hence residence type influences level of active male partner participation in maternal health care services in Lira district

The findings from this study also showed that there was a mean difference between men's levels of education and men's levels of active participation in maternal health services showed by F-value of (6.89>3.23) .A P-value (0.014<0.05) shows that there was a significant relationship between men's levels of education and men's levels of active participation in maternal health services. The findings imply that level of education greatly influences men's level of active participation in maternal health services in Lira district.

The findings shown that there was a mean difference between men's employment status and men's levels of active participation in maternal health services showed by F-value of 4.5>3.23. A p-value of (0.000<0.05) showed that there was significant relationship between employment status and level of AMPP in maternal health services. The findings imply that employment status of men influences active participation in maternal health services in Lira district.

The findings from the study showed that there was no mean difference between religion affiliations groups and men's levels of active participation in maternal health care services as shown by a F-value (1.05<3.23). The findings of this study also revealed that there was no significant relationship between religion affiliations groups (Catholic, protestant, Muslim and others) and men's levels of active participation in maternal health care services as shown by a P-value (0.270>0.05). Religion does not influence men's level of active participation in maternal health care services in Lira district

The findings from the KI interviews, some of the nurse midwives interviewed about their perceptions about what active male partner participation is and they reported that

> "Since active male partner participation is intended to benefit the wife and their unborn child, active male partner participation had to occur before, during and after the baby's birth.

To realize this, the nurses suggested that active male partner's participation during the child's growth, irrespective of their contributions during the antenatal and delivery periods is more important. The nurses also advised men to partake of roles like helping feed the baby when the mother is tired, bathing the baby among other roles.

However different nurses had different understanding of what exactly "Active male partner participation is and in this regards the nurses had the following understandings for what they think AMPP is;

> "When a man prepares for a pregnancy, supports the wife financially and gives her company to the hospital for antenatal visits. Even during delivery, men should provide practical physical and social support to women".
> "…is when men take their female partners to hospital for safe delivery. It also includes men ensuring that children get good health as well as monitor their growth at home".
> "…is where a couple shares responsibilities during pregnancy and feeding the infant. We need men not only to accompany wives but to have interest in what happens at ANC, like having the HIV test together".

This study finding challenges the findings of a study conducted by Babalola and Adesegun, (2009) which established no significant statistical relationship between age and use of skilled assistance during delivery because this found majority of couples were above the age of 31 and above and likely know the ultimate or articulate the benefits of skilled ANC .

The findings of this study agrees with Carter and Speizer, (2005) which revealed that male partner's attendance at prenatal care, delivery and postpartum care services with secondary or tertiary or university education were more likely than their less educated counterparts to participate in birth related activities. Iliyasu,et al. (2010) in Northern Nigeria assessed birth preparedness, complication readiness and father's participation in maternity care, and established that male partners who have attained formal education are more likely to participate in maternity care compared to those with non-formal education and this also agrees with the findings of this study.

The study findings of this research agrees with Mbonye, et al. (2010) and Koo et al. (2013a) concluded that men's communication about reproductive matters with his spouse is a means of taking on shared responsibilities and Villar-Loubet, et al. (2013) described it as a means for common decision making concerning sexual and reproductive health services like HIV testing with their spouse share ideas about sexual issues and Madiba and Letsoalo, (2013) and Musheke, et al. (2013,) also observed that support for the pregnant spouse's disclosure of HIV infection.

The findings from this study agrees with Mbonye, et al. (2010) and Koo et al. (2013a) concluded that men's communication about reproductive matters with his spouse is means of taking on shared responsibilities and Villar-Loubet, et al. (2013) and Aarnio, et al. (2009,) described it as a means for common decision making concerning sexual and reproductive health services like HIV testing with their spouse share ideas about sexual issues and Madiba and Letsoalo, (2013) and Musheke, et al. (2013,) also observed that support for the pregnant spouse's disclosure of HIV infection.

The study findings also confirmed that, with according to studies conducted by (Kasenga et al. (2010); Mbonye, et al. 2010; Oladokun, et al. 2010; Peltzer, et al. 2010; Gilles, et al. 2011; Maman, et al. 2011; Kalembo, et al. 2013; Koo, et al. 2013a; Kwambai, et al. 2013; and Villar-Loubet, et al. 2013) concluded that shared responsibilities included male partners encouraging their expectant spouses to take part in different skilled antenatal care activities such as for HIV counselling and testing and Madiba and Letsoalo (2013) and Musheke et al. (2013) observed that also issues such as the male partner's supportive attitude to his spouse's disclosure of her HIV+ status or generally loving and caring attitude toward an HIV positive spouse as observed by (Nkuoh, et al. 2010; Maman, et al. 2011 and Musheke, et al. 2013) and finally taking up in PMTCT/eMTCT services care programs implementation during prenatal and postnatal phases shows male partner's importance in decision making for family health requires active male partner participation in these activities. Therefore, most respondents do

not care whether or not their spouses have attended antenatal care and have the transport of reaching there and this could be partly due to poverty.

The study findings agrees with the study's findings conducted by (Kasenga, et al. 2010; Mbonye, et al. 2010; Oladokun, et al. 2010; Peltzer, et al. 2010; Gilles et al. 2011; Maman, et al. 2011; Kalembo, et al. 2013; Koo, et al. 2013a; Kwambai, et al. 2013; and Villar-Loubet, et al. 2013) have both concluded that shared responsibilities included male partners encouraging their expectant spouses to take part in different skilled antenatal care activities such as for HIV counselling and testing and Madiba and Letsoalo, (2013) and Musheke, et al. (2013) observed that also issues such as the male partner's supportive attitude to his spouse's disclosure of her HIV+ status or generally loving and caring attitude toward an HIV positive spouse as observed by Nkuoh, et al. (2010); Maman, et al. (2011) and Musheke, et al. (2013) and finally taking up in PMTCT/eMTCT services care programs implementation during prenatal, pre-natal and postnatal phases shows male partner's importance in decision making for family health requires active male partner participation in these activities. Auvinen, (2014) observed that spousal communication and taking care of the family was concluded as a mean of shared responsibility.

5.1.3 Factors influencing the observed level and nature of male partner participation in skilled maternal care services

The findings from this study found out the different factors that is attributed to having impact on the level and nature of active participation in maternal care services as told by both male and female partners and was ranked by percentages and they included; - 16% of the respondents said male partners are left out unattended to by nurses at maternal health centres when they accompany their spouses, 15% of the respondents said that men have busy schedules as bread earners and fear for HIV testing respectively. 14% of the respondents said that maternal health care services is a woman's responsibility and a lot of time is wasted at the maternal health care centres, 12% of the respondents said that the nurses generally do not

see men as important in maternal health care services, 6.7% of the respondents said that maternal health care centres are far, 4% of the respondents said that health workers do not invite men to maternal health care centres, 3% of the respondents said that messages passed are mainly women centred. The findings showed that the main reason for men's non-willingness of men to actively participate in maternal health care services is men being unattended to by nurses even when they escort their wives for maternal health care centres.

However, the male partners shared their positive motivating factors/their willingness to actively participate in their spouse's skilled maternal care services which included; -

25.5% of the respondents said that perceived complication with wife during pregnancy is the major factor that stimulates them to actively participate in maternal health services; secondly, 18.8% of the respondents said that it is their personal responsibility to actively participate; 16% of the respondents said that to get first-hand information; 9.1% of the respondents said that women failure to disclose important information; 8.2% of the respondents said that couples being given much time at the health centres; 6.7% of the respondents said that maternal health services are free; 6.3% of the respondents said that lack of trust in what women report; and lastly, 6% of the respondents said that they loved being with their wives, 4% said that invitation letter from the health centre was a factor that stimulated them to actively participate in maternal health services. The perceived complication with their pregnant spouses stimulated them more to actively participate in maternal health care services in Lira district.

According to the men, health workers only dealt with the women as men waited outside in most cases. Some health workers were also quoted by the men as being tormentors especially when they put a lot of blame over men on some health issues.

From the FGDs narratives, the study found out that both the males and females unanimously agreed that there's still some bit of attitude of health workers towards both men and expectant spouses/mothers especially the names of some midwives were mentioned towards labouring

women were unacceptable. The midwives were said to use foul bad languages against their expectant spouses/mothers who seek for skilled ANC, delivery and postnatal care services.

Other reasons reported by male partners included but not limited to by hierarchy: - the distance to health facility is far 89 (43.0%); failure by health workers to send for men invitation letter

for men through our spouses to accompany their spouses 54 (26.0%); and finally the men reported gender biased health messages passed targeting more of only women 42 (20.2%).

The findings of this study agrees with other findings which concluded that fewer men see their role as extending to sharing responsibility during pregnancy, childbirth and child care (Nkuoh, et al. 2010), as well as helping with cooking and housework (Kwambai, et al. 2013; Nkuoh, et al. 2010) and improving women's diets (Kwambai, et al. 2013).

This finding agrees with the study done by (Mlay R, Lugina H, Becker S, AIDS Care. 2008) that found out that men aged 20 to 34 years desired to accompany their wives to ANC and labour wards. However, when they go with their wives, the nurse-midwives asked them to remain outside the examination or labour-rooms, making them bored and discouraged.

5.3 Summary of the findings

5.3.1 The Nature of active male partner participation in skilled maternal care services

The findings of this study showed that, male involvement which is the entry point to AMPP is widely practiced than the AMPP and the practice included; escorting their spouses, giving financial support and accepting couple HIV blood testing. However, major components of AMPP are missing such as active participation in decision making processes, domestic chore reduction and shared responsibilities. Nature of male participation was found to be significantly influenced by; men's income status (P-value of 0.001<0.05) with significant mean difference between regular income earners and irregular income earners (A F-value of 7.98>3.23); age at a P-value (0.012<0.05) with a mean difference between age brackets (<30

and 31>) (A F-value of 5.34>3.23); significant relationship between residence type and nature of active male participation in maternal child health care services a P-value (0.270>0.05) with a mean difference between rural and urban men in terms of their nature of active participation in maternal health services (A F-value of 8.2>3.2); significant relationship between level of education and nature of male participation in maternal health services (A P-value of 0.014) with a mean difference between levels of education amongst men and their nature of active participation in maternal health services (A F-value of 6.89>3.23); statistical significant relationship between employment status and nature of active male partner participation in maternal child health care services (A p-value of 0.000<0.05) with a mean difference between employment status and a nature/level of active male participation in maternal child health care services, the F-value (4.5>3.23).

However, no significant relationship between religion affiliations (Catholic, protestant, Muslim and others) and nature in maternal health care services as shown by with of no mean difference between religion affiliations groups and nature of AMPP in maternal child health care services at a F-value (1.05<3.23).

5.3.2 Male partner's level of participation in skilled maternal care services

The findings of this study revealed that, the male partner's levels of active participation in maternal child health care services were found to be low at 19.8%. This finding agrees with the earlier findings by Nkuoh, et al. 2010 and Nantamu, 2011 that the level of men's participation is between 5 to 25%.However, the study also shows that the levels of active participation of male partner has significant relationship with men's income status (regular or irregular) (A P-value (0.001<0.05) and A F-value (7.98>3.23) shows that there is significant mean difference between regular income earners and irregular income earners; a significant relationship between man's age at a p-value (0.012<0.05) and A F-value (5.34>3.23) shows that there is mean difference between age brackets (<30 and 31>) on the level of active male participation in maternal child health care services hence reject the null hypothesis and accept

the alternative hypothesis; a significant relationship between residence type and level of active participation in maternal child health care services at a p-value of (0.003<0.05) and a mean difference between rural and urban residence men and their levels of active participation in maternal child health care services (A F-value (8.2>3.2); a significant relationship between men's levels of education and men's levels of active participation in maternal health services at a P-value (0.014) and a mean difference between men's levels of education and men's levels of active participation in maternal child health care services at a F-value of (6.89>3.23) which gives evidence of rejecting the null hypothesis and accepting the alternative hypothesis; and a significant relationship was found between employment groups and levels of active male partner participation in maternal child health care services (A p-value of (0.000<0.05); and a mean difference was found between men's employment groups and men's levels of active participation in maternal child health care services at a F-value of 4.5>3.23 gives the evidence. However, a no significant relationship was found between religion affiliations groups (Catholic, protestant, Muslim and others) and men's levels of active participation in maternal child health care services as shown by a P-value (0.270>0.05) and with no mean difference between religion affiliations groups and men's levels of active participation in maternal child health care services as shown by a F-value (1.05<3.23), accept the null hypothesis and reject the alternative hypothesis.

The findings from the KI interviews, some of the nurse midwives interviewed about their perceptions about what active male partner participation is and they reported that

"Since active male partner participation is intended to benefit the wife and their unborn child, active male partner participation had to occur before, during and after the baby's birth.

To realize this, the nurses suggested that active male partner's participation during the child's growth, irrespective of their contributions during the antenatal and delivery periods is more important.

The nurses also advised men to partake of roles like helping feed the baby when the mother is tired, bathing the baby among other roles.

However different nurses had different understanding of what exactly "Active male partner participation is and in this regards the nurses had the following understandings for what they think AMPP is;

> "When a man prepares for a pregnancy, supports the wife financially and gives her company to the hospital for antenatal visits. Even during delivery, men should provide practical physical and social support to women".
> "…is when men take their female partners to hospital for safe delivery. It also includes men ensuring that children get good health as well as monitor their growth at home". (KI, Head of nurses, LRRH)
> "…is where a couple shares responsibilities during pregnancy and feeding the infant. We need men not only to accompany wives but to have interest in what happens at ANC, like having the HIV test together".

The findings of this study agrees with Carter and Speizer, (2005) which revealed that male partner's attendance at prenatal care, delivery and postpartum care services with secondary or tertiary or university education were more likely than their less educated counterparts to participate in birth related activities. Iliyasu,et al. (2010) in Northern Nigeria assessed birth preparedness, complication readiness and father's participation in maternity care, and established that male partners who have attained formal education are more likely to participate in maternity care compared to those with non-formal education and this also agrees with the findings of this study.

5.3.2 Factors influencing male partner's level and nature of active participation in skilled maternal care services

The findings from this study reported the different reasons that have had an impact on their level and nature of active participation in maternal child health care services as told by the male partners and ranked by percentages and they included; - 16% of the respondents said male partners are left out unattended to by nurses at maternal child health centres when they accompany their spouses, 15% of the respondents said that men have busy schedules as bread earners and fear for HIV testing respectively. 14% of the respondents said that maternal child health care services is a woman's responsibility and a lot of time is wasted at the maternal

child health care centres, 12% of the respondents said that the nurses generally do not see men as important in maternal health care services, 6.7% of the respondents said that maternal child health care centres are far, 4% of the respondents said that health workers do not invite men to maternal health care centres, 3% of the respondents said that messages passed are mainly women centred. The findings show that the main reason for non-willingness of men to actively participate in maternal child health care services is men being unattended to by nurses even when they escort their wives for maternal child health care centres.

However, the male partners shared their positive motivating factors/their willingness to actively participate in their spouse's skilled maternal health care services to include; -

25.5% of the respondents said that perceived complication with wife during pregnancy is the major factor that stimulates them to actively participate in maternal child health services; secondly, 18.8% of the respondents said that it is their personal responsibility to actively participate; 16% of the respondents said that to get first-hand information; 9.1% of the respondents said that women failure to disclose important information; 8.2% of the respondents said that couples being given much time at the health centres; 6.7% of the respondents said that maternal health services are free; 6.3% of the respondents said that lack of trust in what women report; and lastly, 6% of the respondents said that they loved being with their wives, 4% said that invitation letter from the health centre was a factor that stimulated them to actively participate in maternal health services.

5.3 Policy Implications

Amendment of the national strategy policy guideline for men involvement to include AMPP

The study revealed that there is need to review the national strategy policy for men involvement to bring out clarity on how active male partner participation should be promoted and implemented from both the community and health facility bringing out the roles and responsibilities of all the key stake holders.

5.4 Conclusion

The study findings has shown that there exist a serious problem of unclear understanding of what AMPP exactly means among the health workers, male partners, and their spouses and, is the reasons why AMPP is merely seen as escorting or HIV test and or resources given to spouses,

And this is the reason why male involvement was found to be the most commonly practiced concept rather than active male partner participation, hence attributable to the low level and nature of AMPP in maternal health care services.

So due to missing link between male involvement (MI) & active male partner participation (AMPP) as seen in today-to-today practice; led to low level and nature of AMPP, which has negatively resulted in the high trends of preventable MNCH morbidity and mortality in Lira district and in the whole Uganda at large and the unsupportiveness and irresponsibility of male partners in MNCH, in SRHS and other gender programmes saying it's a woman's responsibility.

5.5 Recommendations.

National level: Government/policy makers

Amendment and re-development of the National strategy policy guideline for men involvement. From male involvement to active male partner participation as the ideal situation that all Ugandan's mothers would wish to see when their male partners become actively participative in all their maternal child health care services affairs unlike how it is today where male partners say MNCH is a woman's responsibilities and most times men claim to be very busy stemming it from the fact that the society looks at them as bread winners.

Increasing collaboration and partnerships between government and other implementing partners. Increases the strengths of advocacy, mobilisation, lobbying and fundraising to increase their chances of survival and sustainability is enhanced.

The NGO Bureau that registers, regulates, controls, monitors and evaluates all registered NGOs. Help in overseeing all registered NGOs under the bureau for the integration of active male partner participation in all their programming hence coverage will be enhanced and there will be increased campaigns.

In Health Promotion

Need to review, re-design and re-orient MNCH, SRHS health care services in the 4 spheres of health promotion (Health education, Health protection, diseases prevention & Public Health policy)

Lira Local Government leadership

Increased public-private partnerships between the public health sectors and private health implementing partners with aim of increasing the strengths of advocacy and widen the coverage of the campaigns to promote and implement active male partner participation. Participatory approach to programming making sure its inclusive and ensuring active participation of all key stake holders including beneficiaries thus enhancing programme ownership and increases solicitation for resources.

In education:

The findings of this study also can be used to review, re-design and re-orient the curriculum and syllabus of institutions of higher learning to start to appreciate the importance of AMPP rather than male involvement in programming of all kinds no matter the sector.

5.6 Potential areas for future research

The following are the suggested areas for further studies:-

Assessment of the effectiveness of NGO strategies in enhancing male partner's active participation in skilled MNCH, SRHS and in other gender programmes.

Assessment of the appropriateness of maternal child health care services given to expectant mothers who arrive late.

Assessment of the appropriateness of maternal child health care clinics on maternal and child morbidity and mortality.

Appendix 1:0

REFERENCES

Adamu and Salihu, 2002. Barriers to use of antenatal and obstetric care services in rural Kano, Nigeria.7-2002.

Ahumuza S. E., Rujumba J.,Nkoyooyo A., Byaruhanga, R. and Rhoda K. Wanyenze 2016. Challenges encountered in providing integrated HIV, antenatal and postnatal care services: a case study of Katakwi and Mubende districts in Uganda. MakSPH-CDC Fellowship Program, Makerere University College of Health Sciences, School of Public Health, P.O. Box 7072, Kampala, Uganda.

Aluisio A. A, Erhardt S, and Simbakalia C, 2007. Field testing of WHO guidelines on integrating gender into HIV/AIDS programmes in Tanzania: summary report. Dar es Salaam, WHO/GTZ/Tanzanian Ministry of Health.

Asiimwe.K.J, Suominen T, and Välimäki M. 2010. Utilization of antenatal services among adolescents in Western Uganda.

Auvinen J. Suominen T, and Välimäki M. 2014. A Description of Male Participation in Prevention of Mother to Child Transmission of HIV Programmes, as Viewed by Luba-Kasai Men and Midwives in the Lusaka District of Zambia:ActaUniversitatisTamperensis 1978 Tampere University Press Tampere 2014

Auvinen J, Suominen T, and Välimäki M. 2010. Male participation and prevention of human immunodeficiency virus (HIV) mother-to-child transmission in Africa. Psychology Health & Medicine 15(3), 288–313.

Auvinen J, Suominen T, and Välimäki M. 2014.Views of Luba- Kasai Men, Zambia, about Prevention of HIV Transmission to Babies. Public Health Nursing; doi: 10.1111/phn.12153 (Epub ahead of print).

Auvinen J, Suominen T, and Välimäki M. 2013.Barriers and Resources to PMTCT of HIV: Luba-Kasai Men's Perspective in Lusaka, Zambia. Journal of the Association of Nurses in AIDS Care, 24(6),

554–568.

Auvinen J, Suominen T, and Välimäki M. 2014. Luba-Kasai Men and the PMTCT of HIV program in Lusaka. Health Promotion International; doi:10.1093/heapro/dat088 (Epub ahead of print).

Auvinen J, Suominen T, and Välimäki M. 2013. Midwives' perspectives on male participation in PMTCT of HIV and how they can support it in Lusaka, Zambia. Midwifery, 30(1), 17–27.

Aluisio A. 2011b. Barriers to male engagement in PMTCT: research from primary stakeholders. Presentation delivered at the sub-regional consultation to discuss strengthening male involvement in the elimination of mother-to-child transmission of HIV, Kigali, Rwanda.

Aluisio A. 2011a. Male antenatal attendance and HIV testing are associated with decreased infant HIV infection and increased HIV-free survival. Journal of Acquired Immune Deficiency Syndromes,

Bawah, A. and Doe, R.. 2013. Male Partner Involvement in Maternity Care in Ablekuma South District, Accra, Ghana, Accra: University of Ghana.

Becker, S., Mlay, R., Schwandt, H., and Lyamuya, E. 2010. Comparing Couples' and Individual Voluntary Counseling and Testing for HIV at Antenatal Clinics in Tanzania: A Randomized Trial. AIDS Behaviour, 14, 558 - 566.

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

Chikhungu L, Bispo S, and Newell M.L. (2016). HIV-free survival at 12 – 24 months in breastfed infants of HIV-infected women on ART: a systematic review

Davis. 2016. Male involvement in reproductive, maternal and child health: a qualitative study of policymaker and practitioner perspectives in the Pacific.

Ditekemena J., Koole O., Cyril Engmann, Richard Matendo, Antoinette Tshefu, Robert Ryderand Robert Colebunders. 2012. Determinants of male involvement in maternal and child health services in sub-Saharan Africa: a reviewhttp://www.reproductive-health-journal.com/content/9/1/ Elizabeth Glaser Pediatric AIDS Foundation, Kinshasa, and Democratic Republic of Congo.

Dharma. 2013. Involvement of males in antenatal care, birth preparedness, exclusive breast feeding and immunizations for children in Kathmandu, Nepal.Bhatta BMC Pregnancy and Childbirth 2013, 13:14

Dudgeon MR and Inhorn MC 2004. Men's influences on women's reproductive health: medical anthropological Perspectives.

Dutki, M. 2010. Male Involvement in The Prevention of Mother- to- Child Transmission of HIV (PMTCT) Program in Kayunga District.Programmatic Activity Report.MUSPH-CDC HIV/AIDS Fellowship Program.

Dumbaugh Mari, Tawiah-Agyemang Charlotte, Alexander Manu, Guus HA ten Asbroek, Betty Kirkwood and Zelee Hill1. 2014. Perceptions of, attitudes towards and barriers to male involvement in newborn care in rural Ghana, West Africa: a qualitative analysis

EbbaSecka. 2010. Men's involvement in care and support during pregnancy and childbirth.A qualitative study conducted in the Gambia.University of Oslo, Institute of Health and Society, Department of General Practice and Community medicine Section for International Health.

Esere, M. O. 2008. Communication in marriage relationship.Unilorin Press Ltd.

Eli Fjeld Falnes; Karen Marie Moland; Thorkild Tylleskar; Marina Manuela de Paoli; Sebalda Charles Leshabari and Ingunn MS Engebretsen. 2011. It is her responsibility": partner involvement in prevention of mother to child transmission of HIV programmes, northern Tanzania. Journal of International AIDS Society, 14, 21.

Furaha August, Andrea B. Pembe, Rose Mpembeni, Pia Axemo and Elisabeth Darj. 2016. Community health workers can improve male involvement in maternal health: evidence from rural Tanzania

Gourlay, A; Birdthistle, I; Mburu, G; Iorpenda, K; Wringe, A. 2013. Barriers and facilitating factors to the uptake of antiretroviral drugs for prevention of mother-to-child transmission of HIV in sub-Saharan Africa: a systematic review. Department of Population Health, Faculty of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK. Tel: _44 (0)2076368636. (annabelle.gourlay@lshtm.ac.uk).

Gyasi R. Mohammed. 2013.Use of Traditional Medicine by HIV/AIDS Patients in Kumasi Metropolis, Ghana: A Cross-sectional Survey.

Kakaire O; Kaye Dan K. and O Osinde M. 2011. Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda.Department of Obstetrics and Gynecology, School of Medicine, Makerere University College of Health Sciences, P.O. Box 7072, Kampala, Uganda.

KalemboFatch W, Du Yukai1, Maggie Zgambo, Qiu Jun. 2012. Male partner involvement in prevention of mother to child transmission of HIV in sub-Saharan Africa: Successes, challenges and way forward.

N. Kapata; P. Chanda-Kapata, M.P. Grobusch; J.O'Grady; S. Schwank; M. Bates; S. Janssen; A. Mwinga; Cobelens F; P. Mwaba and A. Zumla. 2010. Assessment of men's gender attitudes and behaviors, and their involvement in reproductive health and HIV/AIDS in Tanzania. Dares Salaam, Engender Health.

Kariuki K. F. and Seruwagi K. G. 2016. Determinants of Male Partner Involvement in Antenatal Care in Wakiso District, Uganda.Uganda Christian University, P.O. Box 4, Mukono, Uganda. British Journal of Medicine & Medical Research 18(7): XX-XX, 2016, Article no.BJMMR.28056

Titus K. Kwambai; Dellicour Stephanie; Meghna Desai; Charles A. Ameh; Bobbie Person; Achieng Florence; Mason Linda; Kayla F. Laserson and Feiko O ter Kuile. 2013. Perspectives of men on antenatal and delivery care service utilisation in rural western Kenya: aqualitativestudy.KEMRI/CDC Research and Public Health Collaboration, Kisumu, Kenya. Ministry of Public Health and Sanitation, Nairobi, Kenya.

Dan K Kaye, Othman Kakaire, Annettee Nakimuli, Michael O Osinde, Scovia N Mbalinda and Nelson Kakande. 2014. Male involvement during pregnancy and childbirth: men's perceptions, practices and experiences during the care for women who developed childbirth complications in Mulago Hospital, Uganda. Department of Obstetrics and Gynecology, School of Medicine, College of Health Sciences, Makerere University, and P.O. Box 7072 Kampala, Uganda.

Kassa Mihretie, Amanuel Alemu Abajobir and Molla Gedefaw. 2014. Level of male involvement and associated factors in family planning services utilization among married men in Debremarkos town,Northwest Ethiopia

Kirsty Brittain. 2014. Male partner involvement during pregnancy: The missing component in PMTCT adherence in Khayelitsha? School of Public Health and Family Medicine, University of Cape Town, Student number: BRTKIR004 MPH (Epidemiology).

Kululanga Lucy, JohanneSundby, Address Malata and Ellen Chirwa. 2012. Male Involvement in Maternity Health Care in Malawi.

Larissa Jennings, Muzi Na, Megan Cherewick, Michelle Hindin, Britta Mullany and Saifuddin Ahmed. 2014. Women's empowerment and male involvement in antenatal care: analyses of Demographic and Health Surveys (DHS) in selected African countries.

Larissa Jennings, Muzi Na, Megan Cherewick, Michelle Hindin, Britta Mullany and Saifuddin Ahmed. 2014. Women's empowerment and male involvement in antenatal care: analyses of Demographic and Health Surveys (DHS) in selected African countries. BMC Pregnancy and Childbirth 2014, 14:297 http://www.biomedcentral.com/1471-2393/14/297. Department of International Health, Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe St., E5038, Baltimore, MD 21205, USA

Lasee, Ashraf and Becker Stan. 1997. Husband –Wife Communication about Family Planning and Contraceptive Use in Kenya International Family Planning Perspectives, 23 (1):15-20 & 33

Mangeni J. N.; Ann Mwangi. Mbugua Samwel; Vincent Mukthar.2013. Male Involvement in Maternal Health Care as a Determinant of Utilization of Skilled Birth Attendants in

Kenya.ICF International, Calverton, Maryland, USA.Department of Community Health, Moi University, Eldoret, Kenya.

Mullary BC, Beckers, Hindin MJ. 2010. The impact of including husbands in ANC health education services on maternal health practices, Nepal

Mullany. 2010. Women's autonomy and male involvement in antenatal care in Napal: associations and tensions.

Makoni A M, Milton Chemhuru, CleopasChimbetete, Notion Gombe, More MungatiDonewellBangure and Mufuta Tshimanga1. 2016. Factors associated with male involvement in the prevention of mother to childtransmission of HIV, Midlands Province, Zimbabwe, 2015 - a case control study.

Mukobi P. 2012. Assessing The Approaches to Male Partner Involvement In PMTCT/eMTCT In Uganda.

Musheke M. 2013. Factors influencing uptake of HIV testing and non-initiation of and attrition from antiretroviral therapy care in Lusaka, Zambia.

Morfaw et al. 2012. Male participation in prevention programmes of mother to child transmission of HIV: a protocol for a systematic review to identify barriers, facilitators and reported interventions.

Makoni Annamercy, Milton Chemhuru, Cleopas Chimbetete, Notion Gombe, More Mungati, Donewell Bangure, and Mufuta Tshimanga.. 2016. Factors associated with male involvement in the prevention of mother to child transmission of HIV, Midlands Province, Zimbabwe, 2015, a case control study. Department of Community Medicine, University of Zimbabwe, Harare, Zimbabwe. BMC Public Health.

MarelignTilahun and Shikur Mohamed. 2015.Male Partners' Involvement in the Prevention of Mother-to-Child Transmission of HIV and Associated Factors in Arba Minch Town and Arba Minch ZuriaWoreda, Southern Ethiopia.Hindawi Publishing Corporation BioMed Research International Volume 2015, MarelignTilahun;

MEDiCAM. 2003. Male Involvement is Key to Reproductive Health(RHPWG).

Mburu, et al. 2014. Adolescent HIV disclosure in Zambia: barriers, facilitators and outcomes.International HIV/AIDS Alliance, Preece House, 91_101 Davigdor Road, Hove BN3 1RE, UK. Tel: _44 1273 718900. Fax: _441273 718901. (gmburu@aidsalliance.org)

Mihretie Kassa1, AmanuelAlemuAbajobir and MollaGedefaw.2014. Level of male involvement and associatedfactors in family planning services utilizationamong married men in Debremarkostown,Northwest Ethiopia.

Ministry of Health. 2010. Health Sector Strategic Plan III 2010/11-2014/15, Kampala

Martin M.C, et al. 2007. The effects of father involvement during pregnancy. On receipt of prenatal care and maternal smoking, Maternal Child Health

Manjate Cuco Rosa Marlene, Khátia Munguambe, Nafissa Bique Osman, Olivier Degomme, Marleen Temmerman & Mohsin M. Sidat. 2015. Male partners' involvement in prevention of mother-to-child HIV transmission in sub-Saharan Africa: A systematic review, SAHARA-J: Journal of Social Aspects of HIV/AIDS, 12:1, 87-105, DOI: 10.1080/17290376.2015.1123643 To link to this article: tp://dx.doi.org

Nantamu P. 2011. Factors Associated with male involvement in Maternal Health Care Services in Uganda.Makerere University.

Nesane K; Maputle S. M.; and Shilubane H. 2016. Male partners' views of involvement in maternal healthcare services at Makhado Municipality clinics, Limpopo Province, South Africa.African Journal of Primary Health Care & Family Medicine ISSN: (Online) 2071-2936, (Print) 2071-2928.

Nungari G. M. 2014. Factors influencing male participation in antenatal care in Kenya:
A case of Kenyatta national hospital, Nairobi, Kenya. University of Nairobi.

Nkuoh N Godlove., RN, Dipl CMMH, Dorothy J. Meyer, CNM, MPH, Pius M. Tih, MPH, PhD and Joseph Nkfusai, BSc. 2010. Barriers to Men's Participation in Antenatal and Prevention of Mother-to-Child HIV Transmission Care in Cameroon, Africa

Nyandieka L. N, et al. 2016. Male Involvement in Maternal Health Planning Key to Utilization of Skilled Birth Services in Malindi Sub-county, Kenya. Centre for Public Health Research, Kenya Medical Research Institute (KEMRI), P.O. Box 20752, Nairobi 00202, Kenya. Institute of Tropical Medicine and Infectious Diseases, Department of Public Health, Jomo Kenyatta University of Agriculture and Technology, P.O. Box 62000, Nairobi 00200, Kenya.

Nyeko .J. 2006. The national policy guidelines and services standards for reproductive health services, second edition, Kampala.

Nyane L. 2007. Factors associated with Antenatal care dropout among pregnant women in Tororo district.

NyondoA.L., ChimwazaA. F., and MuulaA.Sinjani. 2014. Stakeholders' perceptions on factors influencing male involvement in prevention of mother to child transmission of HIV services in Blantyre, Malawi. School of Public Health, College of Medicine, University of Malawi, P/Bag 360, Blantyre, Malawi

Nompumelelo, et al. 2017: Acceptability and Preferences among Men and Women for Male Involvement in Antenatal Care.Hindawi. Journal of Pregnancy.Volume 2017, Article ID 4758017, 8 pages.https://doi.org/10.1155/2017/4758017.

Oboro VO, et al. 2011, Attitudes of Nigerian women toward the presence of their husband or partner as a support person during labor.

Oladokun R. E., Ige O. and OsinusiKikelomo. 2013. Gaps in preventing mother to child transmission (PMTCT) and human immune deficiency virus (HIV)exposure among infants in a Nigerian City: Implications for health systems strengthening.Department of Paediatrics, College of Medicine, University of Ibadan and University College Hospital, Ibadan, Nigeria.Department of Community Medicine, University College Hospital, Ibadan, Nigeria.Vol. 5(7), pp. 254-259, July, 2013. DOI 10.5897/JAHR2013. 0240. ISSN 2141-2359 © 2013 Academic Journals. http://www.academicjournals.org/JAHR

Osman, et al. 2014. Barriers to male involvement in uptake of Prevention-of-Mother-to-Child-Transmission (PMTCT) of HIV in Sub-Saharan Africa.IOSR Journal of Nursing and Health Science (IOSR-JNHS) e-ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 3, Issue 5 Ver. I (Sep.-Oct. 2014), PP 01-07 www.iosrjournals.org www.iosrjournals.org 1 | Page.

Osuchukwu et al. 2013. University Disproportionate Burden of HIV Prevalence among Men and Women assessing HIV Testing and Counseling Services in Cross River State, Nigeria.University of Calabar, Cross River, Institute of Human Virology, Nigeria (IHVN), United States Agency for International Development, Nigeria (USAID-Nigeria). IOSR Journal of Pharmacy and Biological Sciences (IOSR-JPBS) e-ISSN: 2278-3008, p-ISSN:

2319-7676. Volume 7, Issue 6 (Sep. – Oct. 2013), PP 19-24 www.iosrjournals.org www.iosrjournals.org 19 | Page

Okonofua Friday, Rosemary Ogu, Kingsley Agholor, Ola Okike, Rukiyat Abdus-salam, Mohammed Gana, Abdullahi Randawa, Eghe Abe, Adetoye Durodola, Hadiza Galadanci and The WHARC WHO FMOH MNCH Implementation Research Study Team. 2017. Qualitative assessment of women's satisfaction with maternal health care in referral hospitals in Nigeria.University of Port Harcourt, Port Harcourt, Rivers State, Nigeria.

Obinchemti T. E; Ashunya S.K; Eta-Nkongho E; Halle Ekane G. E; Eugene Belley-Priso.2016. Risk Factors and Barriers to Male Involvement in the Choice of Family Planning Methods intheBuea Health District, South West Region, Cameroon: A Cross-Sectional Study in aSemi-Urban Area.

Onchong' M, Were T, and Osero O.S. 2016. Knowledge, Perception and Level of Male Partner Involvement in Choice of Delivery Site among Couples at Coast Level Five Hospital, Mombasa County, Kenya.Coast Level Firve Hospital, P.O. Box 90231-80100, Mombasa, Kenya1, Department of Medical Laboatory Sciences, MasindeMuliro University of Science and Technology, Department of Community Health, Kenyatta University, P.O. Box 43844-0100, Nairobi, Kenya. For correspondence:

Ongweny-Kidero E. A. 2014. Exploring Male Attitudes on Involvement in Antenatal Care: The Case of Prevention of Mother-to-Child Transmission of HIV in Athi River Sub-Location of Mavoko Constituency, MachakosCounty.UniversityOf Nairobi.

Raju, Saraswati and Ann Leonard. 2000. Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality.New Delhi, India: Population Council.

Ringheim K. 2002. When the client's male: client-provider interaction from a gender perspective. International Family Planning Perspectives 28 (3):170–175.

Salway S. 1994. "How attitude toward family planning and discussion between wives and husbands affect contraceptive use in Ghana", International family planning Perspectives.20 (2), 44-47 & 74.

Sherr L and Croome N. 2015. Involving fathers in prevention of mother to child transmission initiatives, what the evidence suggests: Journal of the International AIDS Society:

Shiyagaya K. N., Shikongo K. K. and Amukugo H. J.2016, 3(5), pp. 602-61). Level of Male Involvement and Factors Influencing Male Involvement in the Prevention of Mother-To-Child Transmission of HIV.Lecturers, School of Nursing and School of Public Health, Faculty of Health Sciences University of Namibia.

Sturke, et al. 2014. A Multi-Disciplinary Approach to Implementation Science: The NIH-PEPFAR PMTCT Implementation Science Alliance. J Acquir Immune DeficSyndr _ Volume 67,

Turinawe E. B.; Jude T. Rwemisisi1; Laban K. Musinguzi1;Marije de Groot1; Denis Muhangi; Daniel H. de Vries1; David K. Mafigiri; Achilles Katamba; Nadine Parkerand Robert Pool. 2016. Traditional birth attendants (TBAs) as potential agents in promoting male involvement in maternity preparedness: insights from a rural community in Uganda.

Tweheyo Raymond, Joseph Konde-Lule, Nazarius M Tumwesigye, and Juliet N Sekandi. 2010. Male partner attendance of skilled antenatal care in peri-urban Gulu district, Northern Uganda.Tweheyo et al. BMC Pregnancy and Childbirth 2010

Theuring Stefanie, Laura F. Jefferys, Philo Nchimbi, Paulina Mbezi, Julius Sewangi. 2016. Increasing Partner Attendance in Antenatal Care and HIV Testing Services: Comparable Outcomes Using Written versus Verbal Invitations in an Urban Facility-Based Controlled Intervention Trial in Mbeya, Tanzania.PLoS ONE 11 (4): e0152734. doi:10.1371/journal.pone.0152734.

UNFPA 2003. Takes two partnering with men in reproductive and sexual health NY: UNFPA.

Vermeulen E., A. Solnes Miltenburg, J. Barras, N. Maselle, M. van Elteren and J. van Roosmalen. 2016. Opportunities for male involvement during pregnancy in Magu district, rural Tanzania. African Woman Foundation, Mwanza, Magu District, Tanzania. Department of Community Medicine, Institute of Health and Society, Medical Faculty, University of Oslo, Oslo, Norway.

Vermeulen, et al. 2016. BMC Pregnancy and Childbirth 16:66 DOI 10.1186/s12884-016-0853-8

Marius ZambouVouking, Christine Danielle Evina, CarineNouboudemTadenfok, 2014. Male involvement in family planning decision making in sub-Saharan Africa- what the evidence suggests

Wachira, et al. 2014. Health facility barriers to HIV linkage and retention in Western Kenya.

Wachira, et al. 2012. Factors underlying taking a child to HIV care: implications for reducing loss to follow-up among HIV-infected and -exposed children.SAHARA-J: Journal of Social Aspects of HIV/AIDS,Taylor and Francis Group, LLC. DOI: 10.1080/17290376.2012.665255.
http://dx.doi.org/10.1080/17290376.2012.665255

Walston Naomi. 2005. Challenges and Opportunities for Male Involvement in Reproductive Health in Cambodia. POLICY Project/Cambodia

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

WHO. 2007. Fatherhood and health outcomes in Europe.WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark.

Calistus Wilunda; Gianluca Quaglio; Giovanni Putoto; Peter Lochoro; Givanni Dall'Oglio; Fabio Manenti; Andrea Atzori; Rose Miligan Lochiam; Risa Takahashi; Aline Mukundwa and Koyejo Oyerinde. 2014. A qualitative study on barriers to utilization of institutional delivery services in Moroto and Napak districts, Uganda: implications for programming. Wilunda et al. BMC Pregnancy and Childbirth 2014, 14:259.

APPENDIX 1.2: Thesis Work Plan

Table Show Work Plan for the thesis

Activity Description	August 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	March 2018	April 2018
Chapter 1: Title page, background, problem statement, research questions, conceptual framework, theoretical models, goal, Aim, objectives & justification (Max: 10 pages)									
Chapter 2: Literature Review (At least max. 30 pages)									
Chapter 3: Methodology from study area, to work plan & budget, design, instruments, study samples (Max. 10 pages)									
Proposal Approval and defence									
Chapter 4: Data collection, Data organization, Results(max. 15 pages)									
Data Analysis and presentation									
Interpretations of Results/Findings									
Chapter 5: Discussion of results, conclusion, , & (max. like 6-7 pages)									
Lessons learnt, recommendations, self-evaluation and general conclusion (1-3 pages)									
Thesis Defence									

APPENDIX 1.3: Proposed Budget for the Thesis

Table Show the Proposed Budget

SN	Particular	Unit of measurement	No. of units	Frequency	Unit cost (Ugx)	Amount (Ugx)
1	Scholastic items	Pieces	1	1	150,000=	150,000=
2	Audio machine Recorder	Piece	1	1	50,000=	50,000=
3	Transport (Kampala-Lira)	Person	1	4	20,000=	80,000=
4	Transport (Boda boda) Researcher + Assistants	Persons	4	10	10,000=	400,000=
6	Local Village guide	Persons	4	10	5,000=	200,000=
7	Meals	Persons	5	10	5,000=	250,000=
	Total					**1,180,000=**

APPENDIX 1.4 Questionnaire

Interview guide for male partners in skilled ANC, delivery and postnatal care services

Identification(To be filled in by the interviewer)	**CODES**
Name of Interviewer:_____	**{……..}**
Date of interview: _____	**{……..}**
Questionnaire _umber: _____	**{……..}**
Name of Village:_____	**{……..}**
Parish:_____	**{……..}**
Sub county:_____	**{……..}**
Respondents ID number _____	**{……..}**

Interview start time (12hrs)……

SECTION .A. Characteristics of male partners

No	**Question**	**Responses**	**Code**	**Comment**
1a	How old are you?	……..... years		
1b	Asked whether it influence level/nature	Yes No		
2a	Where do you stay	Rural Area Urban centre	1 2	
2b	Asked whether it influence level/nature	Yes No		
03	What is your religion?	Catholic Protestant Muslim Pentecostal SDA Others…… (specify	1 2 3 4 5 6	
3b	Asked whether it influence level/nature	Yes No		
04	What is the highest level of education you attained?	No education Primary Secondary Tertiary institution	1 2 3 4	

05	What is the highest level of education of your wife?	No education Primary Secondary Tertiary institution University	1 2 3 4 5	
5b	Asked whether it influence level/nature	Yes No		
06	What is your employment status?	Employed Unemployed	1 2	
6b	Asked whether it influence level/nature	Yes No		
07	Who is the income earner in your family? (Working for pay)	Only husband Only wife Husband and wife Neither husband nor wife	1 2 3 4	
08	Men's income status	Regular Irregular	Yes No	
8b	Asked whether it influence level/nature	Yes No		
08	What is your marriage relationship?	Monogamous Polygamous Co-habiting Others	1 2 3 4	
09	Do you live together with your wife who is /was pregnant?	Yes No	1 2	
9b	Asked whether their marriage type it influence level/nature	Yes No		
10	How many children do you have?	1 2 Less than 3 4 above	1 2 3 4	
11	Does your wife reside in the same homestead with your mother?	Yes No	1 2	
SECTION. A: Male partner's knowledge in skilled ANC, deliver and postnatal care activities				
12	Which of the activities take place in skilled ANC, delivery and postnatal care services	Taking weight Taking blood Taking BP Health education Giving medication Resting urine Others (specify……) Not sure	1 2 3 4 5 6 7 (→Section E)	
13	Which of the activities take place within the examination room during ANC days	Palpation Listening to fatal heart Giving medication	1 2 3	

		Others (specify…..) Not sure	4 (→Section E)	
SECTION C: Level of active male partner participation in skilled ANC, delivery and postnatal care services				
14	Have you heard about skilled ANC, delivery care and postnatal care services	Yes No	1 2	
15	Do you think skilled ANC, delivery care and postnatal care services check-ups are necessary?		Yes No	
16	Did your spouse/wife receive skilled ANC, delivery care and postnatal care check-ups?		Yes No	
17	If yes, how many times did your spouse/wife receive ANC, delivery and postnatal services?		1 2 3 4 None	
18	How often do you accompany your partner for ANC services	Always Some times Regular When available	1 2 3 4	
19	Did you and your partner plan to attend ANC during your last pregnancy?	Yes No	1 2	
20	Did you personally attend the Last ANC day with your partner	Yes No	1 2(→31)	
21	How did you reach an agreement to accompany your partner for ANC services at the health facility	Invited by wife Letter from health worker Other (specify……)	1 2 3	
22	Were you comfortable with accompanying your partner for ANC services?	Yes No	1 2(→31)	
23	It is important for a man to accompany his wife for ANC services?	Yes No	1 2(→Sec.34{b}))	
24	Which are the benefits associated:	Ask Respondent to List them		
25	What are the reason you or some men don't accompany their partners for ANC days	Ask Respondent to List them…..		
26 a	At Skilled ANC- How many expectant spouses/mothers	Level 1 Level 2 Level 3 Level 4		
26b	At skilled ANC How many male partners are there	Level 1 Level 2 Level 3		

		Level 4		
27a	At Skilled delivery clinic- How many expectant spouses/mothers	Level 1 Level 2 Level 3 Level 4		
27b	At skilled delivery clinic How many male partners are there	Level 1 Level 2 Level 3 Level 4		
28a	At skilled postnatal care clinic How many women are there	Level 1 Level 2 Level 3 Level 4		
28b	At skilled postnatal care clinic How many male partners are there	Level 1 Level 2 Level 3 Level 4		

SECTION. D. Nature of male partner participation in skilled ANC, delivery and postnatal care services

No	Questions	Responses	Code	Comment
29	Provides financial support to partner as transport to attend ANC, delivery & postnatal	Yes No		
30	Discusses with partner information or interventions given in skilled ANC, delivery & postnatal.	Yes No		
31	Voluntarily take time to find out what goes on in skilled ANC, delivery & postnatal clinics	Yes No		
32	Been with her during labour	Yes No		
33	Been with her in group health discussion	Yes No		

SECTION. E: Related factors for the observed level and nature of active male partner participation in skilled ANC, delivery and postnatal care services.

No	Questions	Responses	Code	Comment
34	To what extent can you say that men do no accompany their wives for ANC because of lack of knowledge of ANC?	large extent Some extent Small extent Not sure	1 2 3 4	
35	To what extent can you say that men do not accompany their wives for ANC because of lack of	large extent Some extent Small extent	1 2 3	

	finance?	Not sure	4	
36	To what extent can you say that long distance for ANC is the reason men do no accompany their wives?	large extent Some extent Small extent Not sure	1 2 3 4	
37	To what extent can you say that cultural taboos is the reason men do not accompany their wives for ANC to the health centres	large extent Some extent Small extent Not sure	1 2 3 4	
38	To what extent can you say that negative attitude by men is the reason they do not accompany their wives for ANC?	large extent Some extent Small extent Not sure	1 2 3 4	
39	To what extent can you say that men's negative perception towards ANC is the reason they do not accompany their wives for ANC?	large extent Some extent Small extent Not sure	1 2 3 4	
40	To what extent can you say that …… is the reason men do not accompany their wives for ANC?	large extent Some extent Small extent Not sure	1 2 3 4	

Interviewer: Please thank the Respondent

Thank you

APPENDIX 2.4 Focus Group Discussion Guide for the Women

Date: ……Group Interviewed: ……

Completed by: ……...

My name is **Achar Emmanuel Molo** from Uganda Martyrs University, Nkozi, Reg No: 2015-M282-20021, conducting a study. The purpose of this discussion is to help us ascertain the level, nature and other related factors to active male partner participation in skilled antenatal care programmes in both public and private health facilities in Lira district. The purpose of calling for you to be part of this discussion today is to learn more from your thoughts, feelings, experiences, challenges and strategies you suggest for solving the challenges you face. Your insights will surely be so helpful in making improvements in skilled ANC services provision.

Your Safety…whatever is discussed here remains confidential/it's a private matter. Your opinion in regard to this topic/issue is highly respected. Nothing you say will be used against you people or any individual in this group or personally attributed to you in any reports that result from this focus group discussion.

Your participation is totally voluntary. Are you willing to participate? **Yes** ☐ **No** ☐

Do you have any questions before we begin? Please do ask, feel free. **Yes** ☐ **No** ☐

1. Have you ever had of Antenatal Care services in any health facility?

2. What do you know about Antenatal care?

3. Have you ever gone for Antenatal care services from any facility?

4. As a mother how many times did you go for antenatal care services in the course of your last or present pregnancy

5. Whom do you usually go with or accompanies you?

6. If your husband accompanies you, how often?

7. Does he readily accepts and knows that it is part of his role to participate?

8. If no, what are the reasons for his low involvement?

9. Sometimes you go to the health facility and may not be served to your expectation, what do you do in such a situation?

10. How far is your nearest health facility? and does it have any effect to your ANC attendance?

11. What is your opinion about the level of men accompanying their wives for ANC, delivery and postnatal care services?

12. In your opinion what should be done to improve male involvement in ANC, delivery and postnatal care services?

13. What should be done to improve utilization of ANC, delivery and postnatal care services?

Thank you for your time!

Probing questions samples

Qn1. What do you know about ANC services?

Probes. Who is the intended user?
Who should attend?
What are the services offered?

Qn2. Do men in this area accompany their wife for skilled ANC, delivery or postnatal care services?

Probes. What are the benefits of men attending these with their spouses?
To the mother?
To unborn baby and the new-born?
To the father?

Qn3. What could be the reasons that prevent men to accompany the wife for ANC?

Probes, Culture issues? Any social economic issue?
Health unit related factors?
Knowledge gaps of what is done at the health facilities?

Qn4. What do you suggest that the health service managers and the health workers need to do to encourage male involvement in ANC services?

Qn5. What about you as the men and community members, what are you going to do to improve male involvement in ANC services?

Qn6. Why is it that some pregnant women do not attend ANC services in health facilities?

Probes. Any influence from the husbands?
Any power /social economic issues?
Any community issues?
Any health facility issues?

Qn7. What should be done to improve health facility deliveries and attendance of ANC care services?

Probes. Any issues on male involvement?
Any health facility issues?
Any community issues?

Thank you very much for your time and information

Do you have any questions or comments on the above issues we have been discussing?
(Answer any questions raised and thank the participants before closure of the session)

APPENDIX 2.5: Focus Group Discussion Guide for the Male Partners/Men

Date: ……Group Interviewed: ……

Completed by: ……...

My name is **Achar Emmanuel Molo** from Uganda Martyrs University, Nkozi, Reg No: 2015-M282-20021, conducting a study. The purpose of this discussion is to help us ascertain the level, nature and other related factors to active male partner participation in skilled antenatal care programmes in both public and private health facilities in Lira district. The purpose of calling for you to be part of this discussion today is to learn more from your thoughts, feelings, experiences, challenges and strategies you suggest for solving the challenges you face. Your insights will surely be so helpful in making improvements in skilled ANC services provision.

Your Safety…whatever is discussed here remains confidential/it's a private matter. Your opinion in regard to this topic/issue is highly respected. Nothing you say will be used against you people or any individual in this group or personally attributed to you in any reports that result from this focus group discussion.

Your participation is totally voluntary. Are you willing to participants? **Yes** ☐ **No** ☐

Do you have any questions before we begin? Please do ask, feel free. **Yes** ☐ **No** ☐

1. Have you ever had of Antenatal Care services in any health facility?

2. What do you know about Antenatal care?

3. Have you ever gone for Antenatal care services from any facility?

4. As a husband (s) how many times did your wife/wives go for antenatal care services in the course of your pregnancy?

5. Whom does she usually go with or accompanies her?

6. If you-the husband accompanies her, how often?

7. What factors drive you to accompany your wife/wives for ANC?

8. If not you, why doesn't you (what reasons do you have for not accompanying your wife/wives for ANC) accompany your wife for ANC, delivery and postnatal?

9. How far is your nearest health facility? and does it have any effect to your ANC attendance?

10. What is your opinion about the level and nature of men accompanying their wives for ANC, delivery and postnatal care services?

11. In your opinion what should be done to improve male partner's participation in ANC, delivery and postnatal care services?

12. What should be done (new strategies you people think can) to improve male partner's participation and utilization of ANC, delivery and postnatal care services?

Appendix 2.6: Interview guide for the Health worker.

My name is **Achar Emmanuel Molo** from Uganda Martyrs University, Nkozi, Reg No: 2015-M282-20021,

As a health worker at this facility, I know you have carried out a number of duties and roles on daily routine. However, I would like you to share with me something about active male partner participation in ANC, delivery and postnatal programs.

1. Apart from other services, do you personally participate in ANC, delivery and postnatal activities?
2. Do you offer antenatal services in your facility?
3. How is the turn up of pregnant mothers?
4. How regular do women antenatal attendance?
5. Do men accompany them in most cases?
6. If in any case there is low male participation, does it have any effects on antenatal service delivery?
7. What is your opinion about the level of men accompanying their wives for ANC, delivery and postnatal care services?
8. Are men happy about the antenatal setting where men and their pregnant wives are tested together for HIV?
9. Does the state of health facility and health services affect antenatal care attendance?
10. Do you have any other reason why there is low male involvement in antenatal care**?**
11. What do you suggest should be improved upon?
12. What do you think should be done to increase the number of husbands of attending ANC days?
13. In your own opinions, what should be done (new strategies) to improve active male partner participation and utilization of ANC, delivery and postnatal care services?

Thank you for your co-operation

Appendix 2.7: Consent form (Luo in (Langi/Acholi), English and kiswahili)
Consent form for Focus Group discussion

Knowledge about active male partner participation in skilled antenatal care programs.

Demographic data of participant

I (Name):_____ Age (in years):_____ Gender (female/male):_____

Village: _____ Primary Occupation: _____

Education: _____ Religion: _____

Status: _____ No. of Children: _____ Signature----------

After satisfactory explanation told to me about the study, fully understood and so, I have agreed to participate in the study willingly and can opt out at any point in time if I decided. You are invited to participate in a Focus group discussion about your knowledge about active male partner participation in skilled antenatal care services.

This study is part of my last task towards fulfilment for the award of master's degree in public health in health promotion of Uganda Martyrs University (UMU), Nkozi.

If you decide to participate, we will talk about;

1. Have you ever had of Antenatal Care services in any health facility?
2. What do you know about Antenatal care?
3. Have you ever gone for Antenatal care services from any facility?
4. As a husband (s) how many times did your wife/wives go for antenatal care services in the course of your pregnancy
5. Whom does she usually go with or accompanies her?
6. If you-the husband accompanies her, how often?
7. What factors drive you to accompany your wife/wives for ANC?
8. If not you, why doesn't you (what reasons do you have for not accompanying your wife/wives for ANC) accompany your wife for ANC, delivery and postnatal?
9. How far is your nearest health facility and does it have any effect to your ANC attendance?
10. What is your opinion about the level and nature of men accompanying their wives for ANC, delivery and postnatal care services?
11. In your opinion what should be done to improve male partner's participation in ANC, delivery and postnatal care services?
12. What should be done (new strategies you people think can) to improve male partner's participation and utilization of ANC, delivery and postnatal care services?

All this information is very important and valid for me because it will help me in informing the planning and policy decision making on how to enhance male partner participation in skilled antenatal care in the future for the benefit of our nation Uganda.

Appendix 2.8: Consent form in (Luo (Langi/Acholi), English and kiswahili)

Consent form to participate in answering the questionnaire

Knowledge about active male partner participation in skilled maternal care programs.

Demographic data of participant

I (Name):_____ Age (in years):_____ Gender (female/male):_____

Village: _____ Primary Occupation: _____

Education: _____ Religion: _____

Status: _____ No. of Children: _____ Signature----------

After satisfactory explanation told to me about the study, fully understood and so, I have agreed to participate in the study willingly and can opt out at any point in time if I decided. You are invited to participate in answering the questionnaire about your knowledge about active male partner participation in skilled antenatal care services.

This study is part of my last task towards partial fulfilment for the award of master's degree in public health in health promotion of Uganda Martyrs University (UMU), Nkozi.

If you decide to participate, you will answer questions around these areas;

1. Have you ever had of Antenatal Care services in any health facility?
2. What do you know about Antenatal care?
3. Have you ever gone for Antenatal care services from any facility
4. As a mother how many times did you go for antenatal care services in the course of your pregnancy
5. Whom do you usually go with or accompanies you?
6. If your husband accompanies you, how often?
7. Does he readily accept and know that it is part of his role to participate?
8. If no, what are the reasons for his low involvement?
9. Sometimes you go to the health facility and may not be served to your expectation, what do you do in such a situation?
10. How far is your nearest health facility? And does it have any effect to your ANC attendance?

11. What is your opinion about the level of men accompanying their wives for ANC, delivery and postnatal care services?

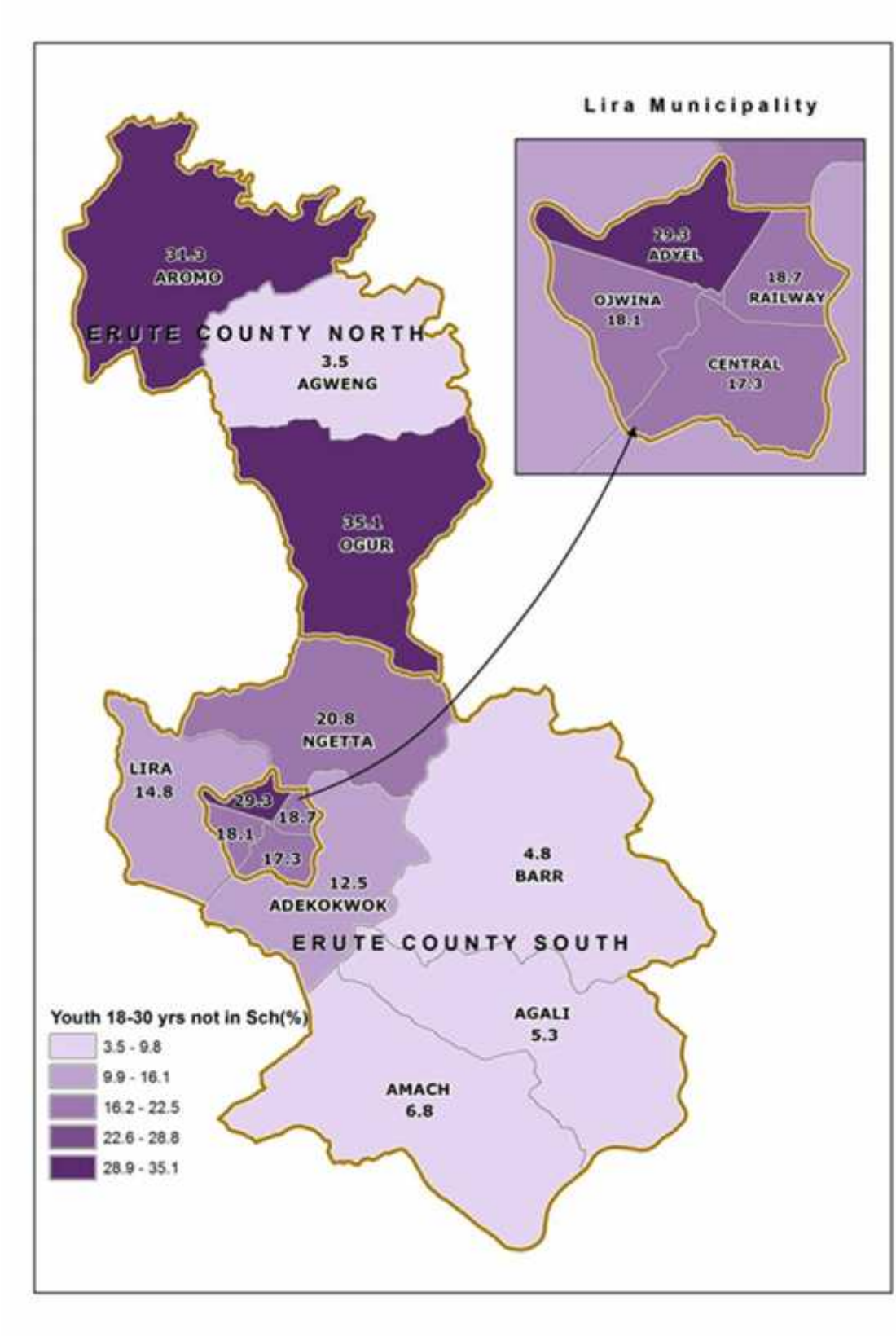
12. In your opinion what should be done to improve male involvement in ANC, delivery and postnatal care services

13. What should be done to improve male partner participation in ANC, delivery and postnatal care services?

Appendix I: Map of Uganda

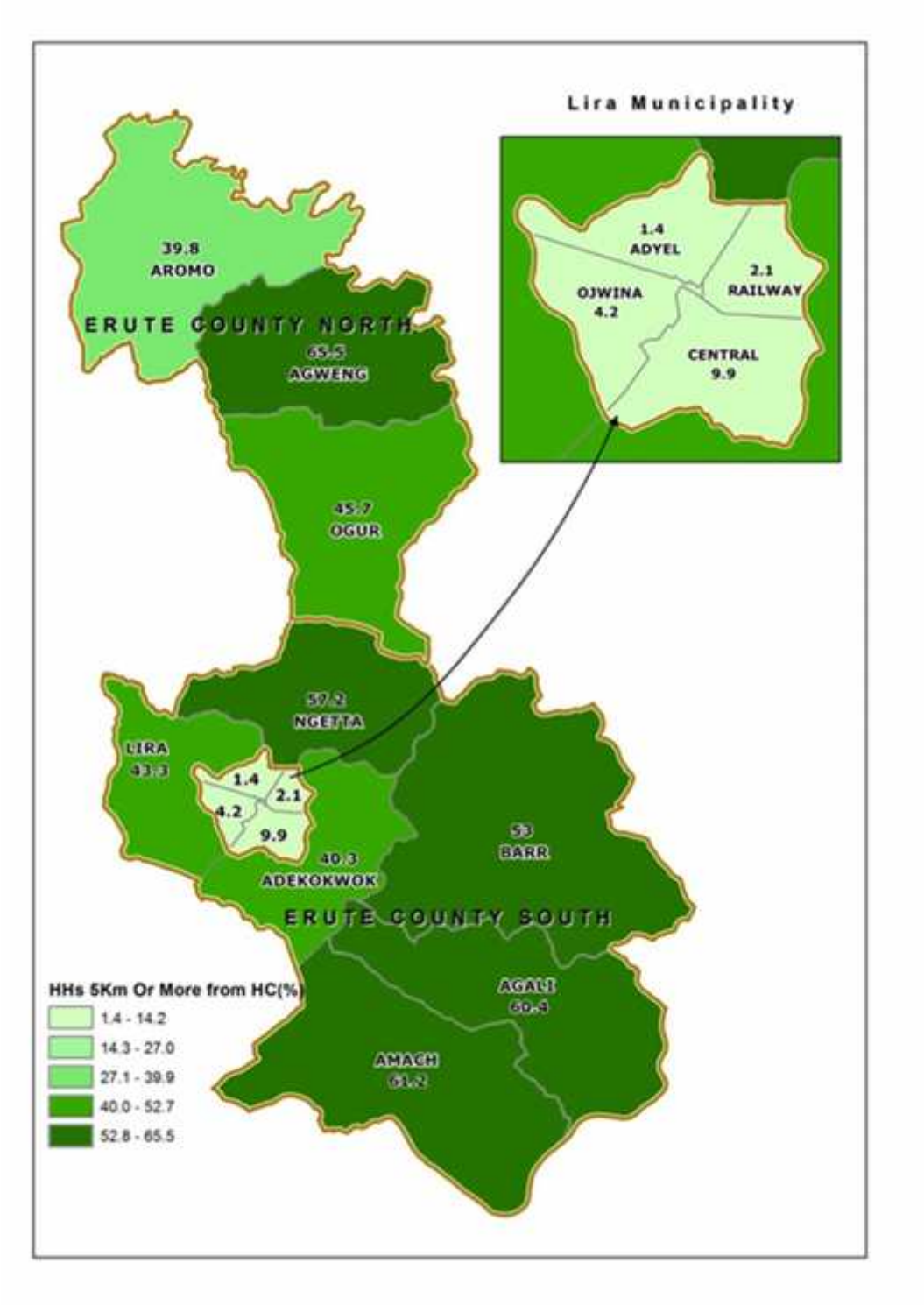
Source: UNDHS, 2014

Map 2: Map of Lira District



Source: UNDHS, 2014

Map 3: Percentage Distribution of Households 5 Km and over, to the nearest Public Health Facility; Lira District, 2014



Source: UNDHS, 2014

One way Anova table showing the difference in means amongst the age groups in active male partner participation in maternal health services

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	29.441	1	9.441	5.34	.012
Within Groups	44.763	356	1.768		
Total	74.204	357			

One way Anova showing the difference in means amongst religious affiliation in active male partner participation in maternal health services

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.095	2	.048	1.05	.270
Within Groups	74.109	355	.045		
Total	74.204	357			

One way Anova showing the mean difference in residence type and active male partner participation in maternal health services

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	41.01	1	17.4	8.2	0.003
Within Groups	33.194	356	2.121		
Total	74.204	357			

One way Anova showing the mean difference in education level of respondents and active male partner participation in maternal health services

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	19.6	3	2.38	6.89	0.014
Within Groups	54.604	354	0.345		
Total	74.204	357			

One way Anova showing the mean difference in employment status of respondents and active male partner participation in maternal health services

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	34.748	1	1.568	4.5	0.000
Within Groups	39.456	356	0.348		
Total	74.204	357			

One way Anova showing the mean difference in income status of men and active male partner participation in maternal health services

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	24.066	1	2.068	7.98	.001
Within Groups	50.138	356	0.259		
Total	74.204	357			

One way Anova showing mean difference in marriage type and active male partner participation in maternal health services

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	25.076	3	3.678	10.56	0.024
Within Groups	.49.128	354	0.348.		
Total	74.204	357			