FACTORS ASSOCIATED WITH MALE PARTNER SUPPORT DURING PREGNANCY AND CHILD BIRTH IN KABALE DISTRICT

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17/A/MPH/084/W

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MAY, 2023

DECLARATION

I declare with utmost faith that the work presented in this research report is my original work and that it has never been either presented or submitted for a Master's degree in any other institution for any academic award.

Signature.

Date: 18th, May 2023.

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APPROVAL FOR SUPERVISORS

I confirm that this research dissertation titled "**Factors associated with male partner support during pregnancy and child birth in Kabale district"** was conducted by the student under my supervision.

Signature

Date: 18th, May, 2023

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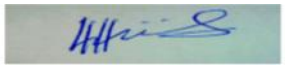
Signature



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DEDICATION

This work is dedicated my wife to my wife Ainamani Bibias, my daughters- Arinda Abigail and Faith Nahabwe for their encouragement and support materially and psychological and to all mothers and fathers who have gone through pregnancy and child birth experiences.

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LIST OF ABBREVIATIONS

ANC: Antenatal Care

LMICs: Low- and Middle-Income Countries

MMR: Maternal Mortality Ratio

PNC: Post Natal Care.

UBOS: Uganda Bureau of Statistics

UN: United Nations

UNICEF: United Nations Children's Fund

UNFPA: United Nations Population Fund

VHTS: Village Health Teams

DEFINITION OF KEY TERMS

Male partner support : Giving instrumental help to female partners through financial help, helping out with physical tasks , providing emotional support , participating in partners' birth plans, providing good nutrition, and communicating with female partner about pregnancy and child health related care . (Bhatta, 2013; Matseke et al., 2017; Montgomery et al., 2011)

Pregnancy: The period in which the fetus develops inside a woman's womb or uterus. (Office on women's health 2010)

Child birth : A process of bringing forth a child from uterus , or womb.(Beck & Huffman, 2019).

Male involvement: In maternal health, it is a deliberate effort by fathers and all men in the society to actively participate in caring for women and supporting their families to access better health services.(Gopal et al., 2020)

Male partner (or father /paternal) involvement: Refer to a man's engagement, interest and participation in the process and experience of pregnancy, child birth and new parenthood **Men's maternal health Care Package**. It is a resource package created for use by health care professionals to help them engage with men during pregnancy and childbirth and to promote active fatherhood.

Gatekeeper. An institutional member empowered to make decisions that affect others (Tannen et al., 2007).

Decision maker: person or group of persons responsible for making strategically important decisions based on a number of variables, including time constraints, resources available, the amount and type of information available and the number of stakeholders involved.

Resource control: Ability to make decision over the use of resources (material, financial human, social and political. In family setting it refers to individual's control over the way family resources are managed.

Health system strengthening: Actions that establish sustained improvements in the provision , utilization, quality and efficiency of health services, including preventive and curative care as well as resilience of the system as a whole (UNICEF, 2016)

Quality of care : The application of medical science and technology in a manner that maximizes its benefit to health with-out correspondingly increasing the risk (Donabedian, 1980)

ABSTRACT

Background: Pregnancy and child births are natural processes but by no means risk-free. Efforts to improve maternal and child's health services have been made, but poor outcomes of pregnancy and child's birth remain high in Sub Saharan Africa. The study sought to assess factors associated with male partner support during pregnancy and child birth in selected public and faith-based health facilities in Kabale district in Uganda.

Methods: The study employed a descriptive cross-sectional design using quantitative approach to assess 318 mothers using convenience sampling method. Both predictor variables that included health facility service factors, social –cultural factors and demographics as well as support as an outcome were assessed using a semi-structured questionnaire. Quantitative data generated from the field was analyzed using descriptive and inferential statistics and presented in frequencies and percentages, and logistics regression was used to trace the associations between study variables and male partner support during pregnancy and child birth at 0.05 level of significance.

Results: The main findings of the study indicate that 216/318 (68%) had low male partner support during pregnancy and child birth and only 102(32%) had high male partner support during pregnancy and child birth. The study found a significant association between health related factors and support women receive from their male partners (OR=1.16, 95%CI: 1.08 to 1.25, p<0.001). Additionally, contextual / social cultural-related factors were also significantly associated with support women received from their male partners during pregnancy and childbirth (OR=1.19 95%CI: 1.03c to 1.38, p=0.017).

Conclusion: The study recommends building capacity of health workers on male support, priotizing the adoption of resource package for engaging men in pregnancy and childbirth and its implementation, awareness through outreaches and media, incentives at each facility for male partners support and community engagement on male support in pregnancy and child birth**.**

Keywords: Pregnancy, Child Birth, Male partner support, Kabale district, Uganda

CHAPTER ONE
INTRODUCTION

1.1 Background of the study

Pregnancy and child birth are natural processes. However, they are by no means risk free. Though various efforts have been made to improve maternal and child health services, the poor outcome of pregnancy and child births remains high due to multiplicity of factors, including medical , obstetric and social economic factors (Naik et al., 2016). Developing countries still suffer from a large number of maternal deaths, and pregnancy and child birth have been regarded risk events in women's lives (Singh et al., 2014a)

Male partner participation in maternity care has evolved over time and varied widely across the world. The 1994 international conference for population and development (ICPD) in Cairo, gave considerable momentum to male involvement programmes. It signalled the explicit recognition by the public health community that engaging with male partners and addressing gender influences was essential for achieving the progress in reproductive health (Daniele, 2021). The World Health Organization (WHO) suggests a focused ANC model to ensure improvement in maternal health. One of the focused models for promoting health of women and children is to support male involvement in maternal health support (World health Organization, 2015).

Evidence from interventional studies in African countries suggest that the three exposure indexes consistently and significantly associated with women's use of skilled birth attendants (SBA's) are: (1) husbands involvement in decision making ,(2) couples' discussion and (3)planning within the house and having received counselling on birth preparedness during ANC (Teklesilasie & Deressa, 2018).

The 2016 WHO recommendations on antenatal care for a positive pregnancy experience recommends "8 visits for women in low and middle income countries instead of four as earlier recommended by the Guidelines Development Group (GDG)(World Health Organization, 2016)". The new 2016 ANC recommendations also highlight the need for interventions that can promote male involvement during pregnancy, intrapartum and the entire postpartum period. Getting on active contributors of ANC and the entire continuum of maternal care symbolizes birth preparedness and complication readiness on the part of both partners , when effective interventions are instituted to have men accompanying their partners to ANC , they will benefit from information delivered during counselling

sessions and therefore appreciate the need to create a conducive psychological , stress-free and conducive environment throughout the season , it will also offer opportunity to health workers to educate men about early recognition of obstetric emergency in order to make appropriate decisions and act in a timely fashion to ensure positive obstetric outcome (Tadesse et al., 2018) .

A systematic review and meta-analysis by Yargawa and Leonardi-Bee on male involvement indicated an association between male support and improved maternal health outcomes especially in developing countries (Yargawa & Leonardi-Bee, 2015). The low involvement of men in maternal health care services results in low utilization of ANC, health facility delivery and postnatal care leading to increased tendency of maternal mortality and morbidity (Craymah et al., 2017). According to Hou and Ma (Hou & Ma, 2011), men can positively affect the prevention of maternal and child mortality by being able to recognize an obstetric emergency, initiate the decision to seek care, and transport pregnant women to obtain health services.

Maternal mortality presents a global health problem with an estimated 295000 women and adolescent girls dying as a result of pregnancy and childbirth related-complications worldwide. Low resource setting accounts for 99% of this number (World Health Organization, 2019). Sub-Saharan Africa accounted for 201,000 (66 %) of all maternal deaths, giving a maternal mortality ratio (MMR) of 546 deaths per 100,000 live births in 2015, compared to an MMR of 12 /100,000 for higher income countries (Alkema et al., 2016). More than 800 women world-wide died each day from preventable causes related to pregnancy and childbirth, and 99% of all maternal deaths occurred in developing countries in 2015.

Uganda recorded a decline in MMR from 438 in 2011 and, currently, the country's maternal and infant mortality rates are 336 per 100,000 and 22 deaths per 1000 live births respectively (Uganda Bureau of Statistics, 2016). Despite this reduction, Uganda's maternal mortality is still unacceptably high (World Health Organization, 2019).

Every day, about 20 mothers die from preventable causes (Uganda Bureau of Statistics, 2016). The country's MMR still falls behind the target for 2030 Sustainable Development Goal 3, of fewer than 70 maternal deaths per 100,000 of global live births (United Nations, 2015).. This therefore means that Uganda will not meet this global target by 2030. There is still a lot desired to ensure that no woman loses her life during pregnancy and birth and no

child dies at birth.

The low participation of men in maternal and child health care is one of the limiting factors to eradication of maternal and infant mortality in Uganda (Morgan et al., 2017; Muheirwe, 2019).

" Male partner (or father /paternal) involvement has been generally used in public health literature to refer to a man's engagement , interest and participation in the process and experience of pregnancy , child birth and new parenthood. However , definitions have varied , ranging from single indicators such as being named in the birth certificate (Alio et al., 2011) or accompanying their partners to ANC consultations (Aluisio et al., 2011) to indices and scales also covering men's provision of various types of social support(Ampt et al., 2015; Hampanda et al., 2020). Other scholars have defined male partner support as "giving instrumental help to female partners through financial help, helping out with physical tasks , providing emotional support , participating in partners' birth plans, providing good nutrition, and communicating with female partner about pregnancy and child health related care (Bhatta, 2013; Matseke et al., 2017; Montgomery et al., 2011). In this study, the researcher focused on the concept of male partner support in terms of financial, physical, emotional, decision making as well as communication during pregnancy and child birth. This study assessed male partners' provision of support during pregnancy as distinct from their involvement. The factors affecting their provision of support were explored.

Studies from several low-income countries show that fewer than 50% of male partners attended at least one ANC consultation. These are studies from Afghanistan and Nigeria (Alemi et al., 2021; Falade-fatila & Adebayo, 2020).In the Pacific, Davis et al , reported male involvement in the broader perspective of safe motherhood to be still inadequate (Davis et al., 2016), Male partner attendance at PNC and well-baby check-ups in the Pacific had received less attention, but was likely to be lower than for ANC.

In Malawi , it was evident that partner support in maternal health care was very low (Kululanga et al., 2012) while in Kenya, infant delivery by skilled providers in Busia was very low due to failure of men to support their partners to access health delivery services (Nanjala & Wamalwa, 2012),

In Uganda, studies have reported male support in maternal and child health care to be low and others unsatisfactory. For instance, a study by Muheirwe and Nuhu in Western Uganda (Muheirwe & Nuhu, 2019), study by Byamugisha and colleagues in Mbale district, in

Eastern Uganda reported low male partner support in prevention of mother to child transmission (Byamugisha et al., 2010), in Gulu-northern Uganda, male support was registered high during ANC visits , but only men with reproductive Health knowledge were willing to attend skilled ANC care (Tweheyo et al., 2010). In Kabale district , male support in the prevention of emergency obstetric referrals was inadequate (Kakaire et al., 2011). A study by Dyogo in Jinja district , revealed that the proportion of males who accompanied their spouses for ANC was low at 42.7%, for delivery 43.4% and 31.7% for postnatal care (Dyogo, 2011). Low male involvement in maternal health care services remains a problem to health care providers and policy makers (Dyogo, 2011). The study by Muheirwe and Nuhu in Kabale district focused only on institutional factors determining male participation in maternal and child health care. The general factors associated with male support in pregnancy and childbirths have not been explored.

1.2 Problem statement

It is worth noting that the MMR in Uganda has fallen by approximately 33% over the past 20 years, from 527/100,000 in 1995 to 336/100,000 in 2016 (Annual Health Sector performance report 2016). This rate is still lower than the global reduction of 45% over the same period. Every day, about 20 mothers die from preventable causes (Uganda Bureau of Statistics, 2016). According to the Uganda Bureau of Statistics (2014), Kigezi region ranked as second region with highest maternal mortality ratio of 541/100,000 live births to Karamoja with 588/100,000 out of the 15 regions (UBOS, 2014). Studies on male involvement have shown that male partner support is associated with improved maternal health outcomes especially in developing countries (Yargawa & Leonardi-Bee 2015.) Other evidence from interventional studies in Africa associate women's use of skilled birth attendants to husbands' involvement in decision making, couples' discussion and planning within the house and counselling on birth preparedness during ANC (Teklesilasie & Deressa, 2018).

Men can positively affect the prevention of maternal and child mortality by being able to recognize an obstetric emergency, initiate the decision to seek care, and transport pregnant women to obtain health services among other roles. The low male partner support in maternal and child health care limits the eradication of maternal and infant mortality in Uganda (Morgan et al., 2017; Muheirwe, 2019).

Kigezi is a patriarchal society and in Kabale district studies have shown that male partner support in maternal and child health is low (Kakaire et al., 2011; Muheirwe & Nuhu, 2019).

Low partner support in maternal health care services result in low utilization of ANC, health facility delivery and postnatal care, leading to increased tendency towards maternal mortality and morbidity. The study therefore aimed at assessing factors associated with male partner support during pregnancy and childbirth in Kabale district.

1.4 Objectives of the study

1.4.1 Overall objective of the study

The overall objective of the study was to assess factors associated with male partner support during pregnancy and childbirth in selected health facilities in Kabale district.

1.4.2 Specific Objectives

1. To determine the proportion of women who received support from their male partners during pregnancy and child in Kabale District.
2. To determine the level of support received from their male partners during pregnancy and childbirth
3. To determine the factors associated with male partners support during pregnancy and child birth in Kabale District

1.5. Research Questions

1. What proportion of women received support from their male partners during pregnancy and child birth

2. What level of support did the women receive from their male partners during pregnancy and child birth?

3. What are the factors associated with support women received from their partners during pregnancy and childbirth

1.6 Justification of the study

Men's support is vital in enhancing maternal and health outcomes. Pregnancy and child birth have traditionally been considered women's domain. The key roles of men in decision making, financial support, physical support informational /communicational and emotional support cannot be underrated. This is because pregnancy and childbirth create a lot of physical, mental, social and emotional demands on the woman's wellbeing and therefore, require men to play central role.

Lack of men's support in pregnancy is a barrier to utilization of maternal health services and

their role as decision makers directly affects their partner's and children's health. Male partners' decisions affect in utilization of resources and access to health care services, use of contraceptives and child spacing, availability of nutritious food and effect on women's workload. Men's actions in terms of abuse or neglect have a direct impact over the health of their partners and children. Thus, having tremendous economic and social power in the family, their support has significant implications.

The deep-rooted social structures of societies they live in have formed an inequity over the power of making decisions. The research was therefore planned to inform interventions aimed at identifying household as well facility level opportunities for engaging men to support for their wives during pregnancy and childbirth.

1.7 Significance of the study

The study intended to document evidence on men's support and the factors influencing male partner support during pregnancy and child birth

The study will be useful in various ways:

It would inform Ugandan Ministry of Health to design interventions aimed at engaging men as drivers of maternal health care.

The study would also help district health educators, and opinion leaders to design appropriate interventions such as information education communication, training programmes for bringing men on board as well as dissemination of men's maternal health care package.

The study would further be helpful in improving the health of mothers and children if male partners prioritize their health care. In addition, religious leaders and opinion leaders would use this research data to inform public and rally men to engage in maternal and child health care services.

Furthermore, this study would serve as a reference for future research for scholars who would be interested in investigations of related studies.

Finally, it is an opportunity for the researchers' fulfillment of his master's degree.

1.8 Scope of the study

1.8 .1 Geographic Scope

The study was conducted in Kabale District. The study participants were selected from four facilities which included two faith-based and two public health facilities. The facilities were

Kamuganguzi Health Centre III, Maziba Health Centre IV, Rugarama Hospital and Rushoroza Hospital. The study participants were all mothers and all fathers in reproductive age who had delivered within the last 12 months prior to the study period in the selected health facilities. The study targeted antepartum postpartum mothers attending to ANC and PNC in selected health facilities in Kabale district.

1.8.2 Content Scope

The study assessed the factors associated with male partner support during pregnancy and child birth. The study focused on individual/demographic, social cultural and health system factors that influence men in supporting and caring for partners during pregnancy and child birth, level and type of support by men in Kabale district selected health facilities.

1.8.3 Time Scope

The study considered period from 1st April 2021 to April 2022. The study considered this period because by April 2022, mothers who gave birth at health facilities would be able to recall their experiences during pregnancy and childbirth to avoid recall bias.

1.9 Conceptual Framework review

The study's independent variables were: individual characteristics of respondents, the socio-cultural factors and health system factors that affect the level of outcome which is male partner support in pregnancy and child birth. In the conceptual below, work, age, educational level, occupation, marital status, knowledge about pregnancy needs and danger signs as well as male partner's individual behavior towards pregnant partner's situation are considered as individual characteristics / factors. Socio-cultural factors considered in the study as affecting male partner support are beliefs, norms in the society, gender norms in the community and traditional approaches to pregnancy and childbirth.

The health facility factors associated with male partner support in the study are health service provider behavior and language use, venue and space constraints, waiting time, quality of care, gender distribution of the staff, Health service provider attitude & commitment, distance to the facility, and provision made for men at antenatal clinic and labor wards during delivery. The outcome variable (Male support in Pregnancy and child birth) are measured by main variables. The outcome variable is support received by mothers in terms of financial, physical, emotional, and communicational/informational and decision making from their male partners.

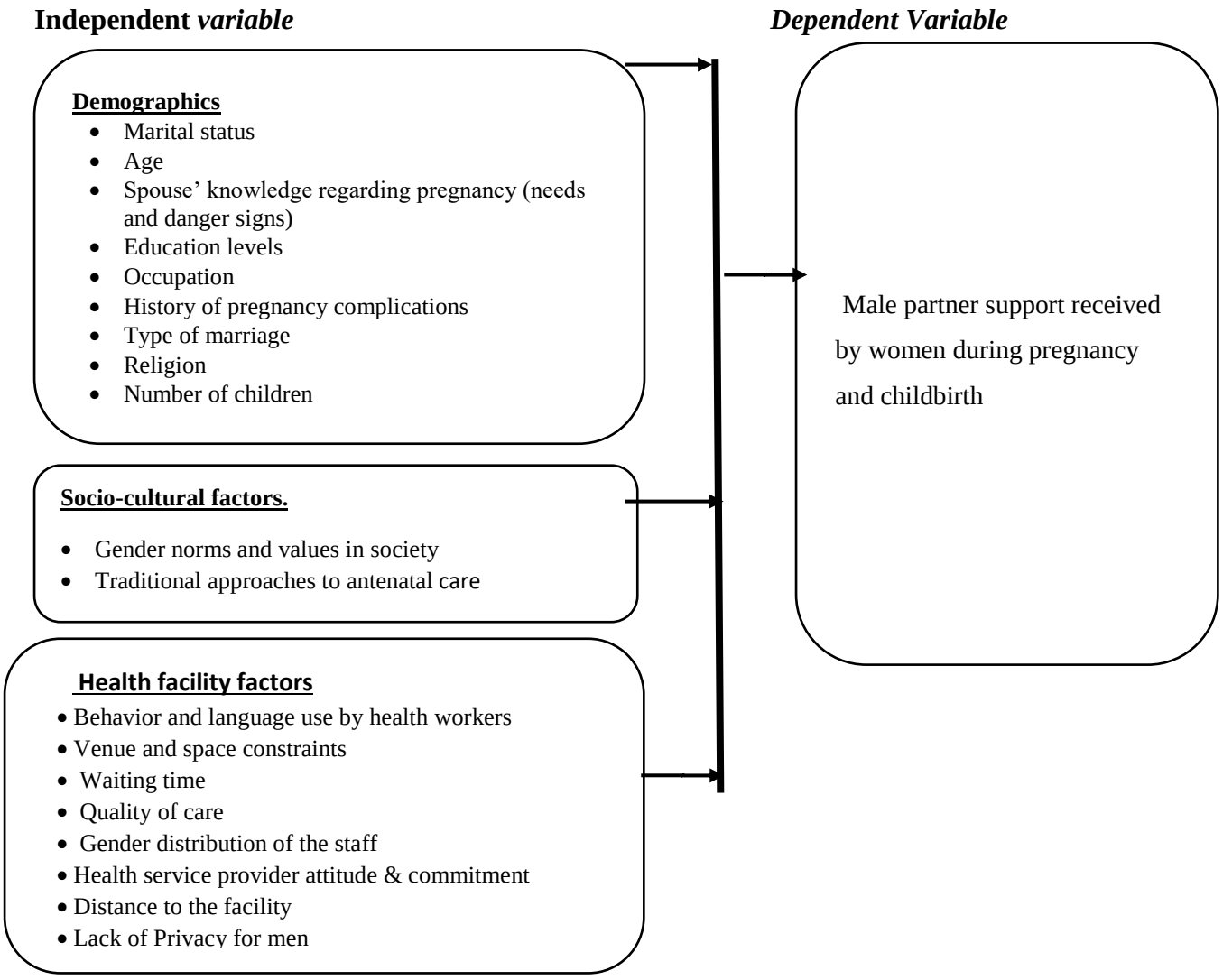

Figure 2: The Conceptual Framework.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews literature on male partners' support during pregnancy and child birth in different parts of the world. The proportion of male partners who support their partners in pregnancy and childbirth, their level of support during pregnancy and childbirth, the factors influencing their support were critically and comparatively reviewed. Finally, the theoretical frameworks on pregnancy and childbirth are also presented and discussed.

2.1. Theoretical conceptual review

Male partner support in pregnancy and child birth-related care in this study were informed by the social support theory. Social support is a positive social interaction and is described as the help provided through social relationships and interactions (Bartholomew Eldredge, percel, Kok, & Gottlieb, 2011). The four main types of social support are emotional (provision of empathy, love, trust, and caring), instrumental (provision of tangible aid and services), informational (provision of advice, suggestions and information), and appraisal (provision of feedback useful for self-reevaluation and affirmation (Bartholomew Eldredge et al., 2011).

Male partner support takes the form of a positive social interaction between two partners in an intimate relationship who, together, need to make efforts and important decisions for the health of the expected baby. A male partner can provide instrumental or emotional support to his pregnant partner who needs antenatal and postnatal care services. In showing support of his female partner, a male partner can encourage her to attend (and accompany her to) antenatal care, help prepare and save money for delivery and arrange transportation to the birthing center, support good nutrition, reduce workload during pregnancy, and provide emotional support (Bhatta, 2013; Vermeulen et al., 2016).

The theory of planned behaviour (TPB) was also used as a guide to explain men's willingness with regard to supporting their pregnant partners during and after pregnancy. The TPB suggests that intention, the most important determinant of behaviour is determined by three conceptually independent constructs: attitude, subjective norms, perceived behavioural control (Ajzen, 1988).

The meaning attached to male partner involvement or support and men's understanding of

their support in ANC and postnatal may be explained by attitudes towards it, their subjective norms, and perceived behavioural control regarding male partner support.

According to TPB, attitudes towards a certain behaviour --male partner support in this case -- are influenced by beliefs about what is entailed in performing the behaviour and outcomes of the behaviour (Glanz & Rimer, 1997). Subjective norms are influenced by beliefs about social standards and motivation to comply with those norms (Glanz & Rimer, 1997). Performance of behaviour is influenced by the presence of adequate resources and ability to control barriers to behavior (Ajzen & Madden, 1986). The more resources and fewer obstacles individuals perceive, the greater their perceived behavioural control and strong intention to perform behaviour(Ajzen & Madden, 1986)

2. 2 Proportion of women who received, support from male partners during pregnancy and childbirth

A community-based cross-sectional study in Bangladesh found out that 60% of the husbands took care of their wives during pregnancy, 44 percent of men took care during childbirth and about 30 percent provided help in postpartum out of the 422 study participants. The spouse discussion with health worker regarding maternal and reproductive health was the most predictor for support to their wives during pregnancy, childbirth and postpartum care. It was indicated that pregnant women living in slums received poorer health-related services when there was low male involvement especially, the husbands of pregnant women (Zakaria et al., 2021).

A recent community-based cross-sectional study of 477 married men by Tessema et al. (2021), in Debre Tabor town East Ethiopia indicates inadequate male partner's involvement in institutional delivery, only 181 (37.9%) husbands/partners were involved in institutional delivery for the most recent child birth (Tessema et al., 2021).The study reported a significant beneficial impact of male involvement on maternal health through improved utilization of institutional delivery.

A study on prevalence of male partners involvement in ANC in Kyela district Mbeya indicate that about 174 women who were visiting, the ANC, in their second to fourth visit, about 56.9 % (99) attended with their male partners and 51% (52) of men accompanied because women had requested to accompany them, attendance of male partner at ANC significantly associated with male partners awareness of ANC visiting dates (Kabanga et al., 2019)

Gibore et al.(2019) in their cross -sectional study on factors influencing men's involvement in antenatal care services in central Tanzania, indicated 53.9% of male attendance in ANC, majority (89%) made joint decisions on seeking antenatal care , 63.4% of men studied accompanied their partners to the ANC Clinic at least once, less than 23.5% of men were able to discuss issues related to pregnancy with their partners' health care providers while about 77.3% of men provided physical support to their partners during the antenatal period. (Gibore et al., 2019)

2.3 Level of men's support during pregnancy and childbirth

Men's support and Involvement confined strictly to traditional gender roles, with men's main responsibility being provision of funds. On the other hand, women, were interested in receiving more support from their husband through planning, attendance to antenatal care and physical presence in the vicinity of where the birth was taking place (Singh et al., 2014b)

A study on knowledge , perception and level of Male partner involvement in Mombasa showed that the level of male partner involvement in choice of delivery site among couples was low (Onchong et al., 2016). A similar study in Kabale District by Muheirwe and Nuhu confirmed a low male participation in maternal and child health services (Muheirwe & Nuhu, 2019). In addition, Kariuki and Seruwagi (2016) study indicate that male involvement in ANC was very low at (6%) of all studied participants in Wakiso district.

Men can support their partners by helping them to prepare for delivery, saving money, arranging transport to the birthing centre, reducing workload during pregnancy and providing emotional support (Bhatta, 2013; Vermeulen et al., 2016). Because men are decision makers and chief providers, they often determine women's access to economic resources and may greatly influence behaviour regarding the use of contraceptives, availability of nutritious food, women's work load and the allocation of money, transport and time for women to attend health services (Nesane et al., 2016)

2.4 Factors affecting male partner support during pregnancy and childbirth

Access to information on men's involvement, religion, occupation, ethnicity, waiting time and men's perception about the attitude of care providers significantly influence men's involvement in antenatal care services (Gibore et al., 2019). Men's involvement in maternity care is influenced by culture-specific maternity-related gender norms compounded by the conditions of deprivation that deny women access to resources with which they could find

alternative support during pregnancy (Id & Bali, 2020). The conceptualization associated with pregnancy and delivery as a woman's domain affects male partner support in pregnancy and child birth care; in addition pregnancy chores do not warrant men's efforts compared to other competing responsibilities and those who help with house chores are subject to mockery (Lowe, 2017).

Male partners' poor knowledge, socio-cultural factors and inadequate and inappropriate services for men hampered the utilization of services and impair support for their pregnant wives' service utilization (Kura et al., 2013). Men who escorted their partners were subjected to gossip by their male counterparts and increasingly by women found in clinics while in the process of seeking care. Husbands' presence during delivery process was often limited by cultural and religious beliefs , attitude of midwives, limited space in clinics and non-cubicle structured labour wards compromising privacy (Helleve, 2010).

Blood pressure screening, fatherhood information, and HIV testing were key incentives for male ANC attendance (Yende et al., 2017), the availability of a male-friendly clinic was considered an important incentive that facilitated men's ANC attendance, compensation to cover transport and opportunity cost for attending the clinic as a motivator to attending ANC and accepting an HIV test (Sakala et al., 2021), Recognition by men of the impact of their involvement , pride , advocacy , incentives and disincentives and male champions are key facilitators to male partner support and maternal and child health (Mkandawire & Hendriks, 2018). The Age difference between husband and wife, age at marriage, women empowerment, type of nearby health facility and male invitation by health providers to antenatal care examination room determined male partner antenatal care involvement (Mamo et al., 2021).

Kariuki and Seruwagi's, (2016) study indicated that Male involvement in ANC was very low at (6%) and attributed to socio-demographic factors such as education marriage and age increases ANC involvement while lower income earnings decrease MI levels. Inconsistent participation in ANC was increased by not living together with their spouses during pregnancy, family members living with male partners and their spouses , family members influencing male partners' decision to get involved in ANC , unplanned pregnancies, peer influence and limited male involvement in deciding where spouses attend ANC. (Kariuki & Seruwagi, 2016). Health worker attitude long waiting time and cost of antenatal services significantly associated with male involvement in ANC (Kariuki & Seruwagi, 2016)

A qualitative study of men' s involvement in maternal and child health in Malawi by Mkandawire and Hendriks show that recognition by men of the impact of involvement, pride, advocacy, incentives and disincentives and male champions facilitated male involvement in Malawi (Mkandawire & Hendriks, 2018)

CHAPTER THREE

MATERIALS AND METHODS

3.0. Introduction

This chapter presents the research methodology that was used in the study. The chapter highlights the research design, study setting, study population, inclusion and exclusion criteria, sample size and sample size determination, Research instruments, Data collection procedures, Quality control, Data management and analysis and Ethical considerations for undertaking the study.

3.1 Research Design

The study employed a cross-sectional descriptive design with quantitative method. The researcher used a structured questionnaire with both closed and open-ended questions. The questions were developed using key variables reviewed in literature, the researcher also adapted the tool used by Prata in his study on male support for family planning and modern contraceptive use in Luanda, Angola (Prata et al 2017) as well as utilization of the contents contained in resource package for engaging men in pregnancy and childbirth

3.2 Study Settings

The study was conducted in Kabale district in selected health facilities. . The district is found in Kigezi region of western Uganda located approximately 410km (255Mi) by road south west of Capital Kampala –Uganda. Kigezi region ranked second to Karamoja with MMR of 541/100,000 live births (UBOS, 2014).

Kigezi is a patriarchal society where men take decisions, and gender roles and norms influence decision making in health seeking care. The Uganda Bureau of Statistics (UBOS) estimated the district Population at 248,700(120,000 Male and 128,700 Females) as of July 2020 (UBOS, 27th October 2020). The district has one Referral Hospital, two privates for nonprofit/faith-based hospitals, 04 health centre 1Vs including Maziba and nine Health Centre IIIs including Kamuganguzi Health centre IIIs and two privates for nonprofit (Ministry of Health Uganda, 2018). The study was conducted in four health facilities (two faith based -non for profit, one Health centre IV, and one public Health Centre III). The health facilities were Rugarama hospital, Rushoroza hospital, Maziba HCIV Maziba and Kamuganguzi III. The facilities provide antenatal care services including deliveries.

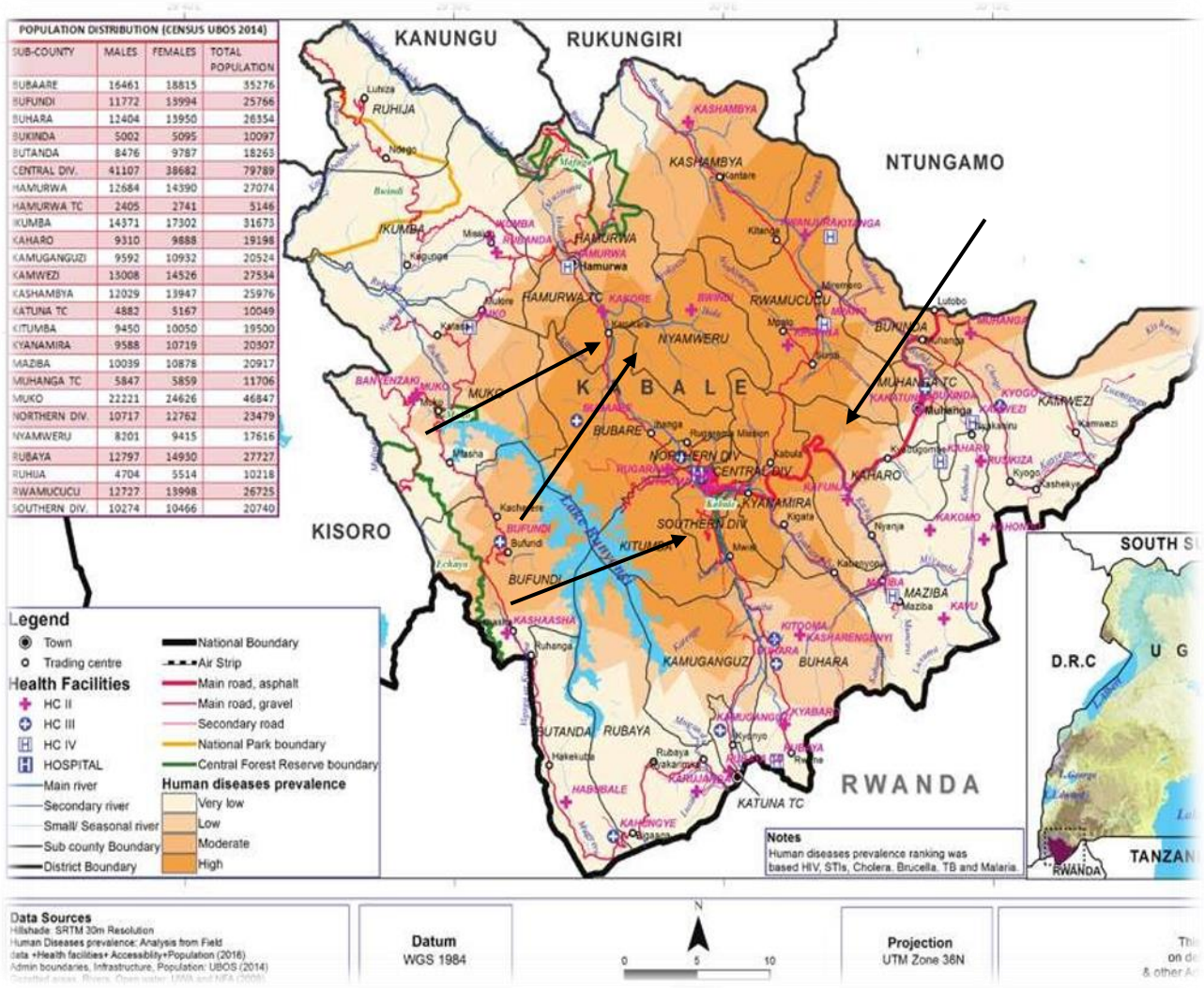

Figure 3: Map of Kabale showing Health facilities under study

3.3 Description of the Population and sample Selection

3.3.1 Study Population

The study was done among mothers of reproductive age (15 to 49 years) who were pregnant or delivered within the last 12 months prior to the study period and were attending Antenatal or postnatal care at the selected four facilities of Kamuganguzi HCIII, Maziba HCIV, Rushoroza hospital and Rugarama hospital.

3.3.2 Target Population

The study targeted mothers in reproductive age who had had pregnancy and child birth within 12 months before preceding the study and were attending to the selected health facilities for ANC and PNC in Kabale district. The study targeted postpartum and antenatal mothers who attended antenatal care in the above selected health facilities

3.4 Sample size determination.

The researcher applied Slovin's formula in determining the sample size.

Slovin's formula is used to calculate the sample size necessary to achieve a certain confidence interval when sampling a population. Slovin's Formula provides the sample size (*n*) using the known population size (*N*) and the acceptable error value (*e*) (Slovin, E.1960) Slovin's Formula for Sampling Technique.

Thus $n = \frac{N}{1 + Ne^2}$

Where n is the sample size, N is the population size and e, is the margin of error that denotes the allowed probability of committing an error in selecting a small representation of the population.

The population of mothers who attended their 4th Antenatal care visit to the four health facilities under study from April to September 2021 were 1,252 (HMIS, 2021). The reason for selecting only mothers of the 4th antenatal visit is that it was the previously recommended ANC by World Health organization before the current 8 antenatal visit recommendation.

Applying this number, 1252 in the formula

Sample size (n) $= \frac{1252}{1+1252x\ (0.05)^2}$

n= $\frac{1252}{1+3.13}$

n= 303.14

Setting the non-response rate at 5 %, the sample size increases to 318 respondents.

Table 1 : Study sample size determination

Respondents	Population Size	Sample Size.
Maziba	251	64
Rugarama Hospital	299	76
Kamuganguzi HCIV	260	66
Rushoroza Hospital	442	112
Total	1252	318

The proportionate sample size for each facility was obtained by;

Getting the individual facility respondents/ total population x sample size

Using an example of Rushoroza 442*1252* 318= 112

As shown in the table above participants for quantitative study were determined using proportionate to sample size for each of the health facility's study population.

3.4.1 Sampling techniques

Selection of health facilities - The researcher applied lottery method of random sampling to select the 04 health facilities. Kabale district has 2 hospitals, 04 Heath Centre IVs and 09 Health Centre IIIs.

Two hospitals of Rugarama and Rushoroza were purposively selected while Health Centre IVs and Health Centre IIIs were combined to make 13 health facilities and assigned random numbers on their separate sheets of paper of similar size and color, folded and mixed up in a box. A blind fold selection was made to select two facilities out of them.

Selection of study participants: Convenience sampling was used to identify mothers who attended to selected health facilities for postnatal and ANC. It's envisaged that during data collection all women who attended Antenatal care had delivered and able to memorize their pregnancy and child birth experiences, in addition, those undergoing ANC were also enrolled. Mothers were enrolled and thereafter assessed for their male partner support to seek for the proportion of women who received support as well as level of support they received.

3.5 Inclusion and exclusion criteria

3.5.1 Inclusion criteria

All mothers attending their ANC and had ever had child birth and those attending for PNC. Only mothers with male partners were included.

3.5.2 Exclusion

Mothers who fall below the reproductive age of 15 years, novice mothers attending their 1st ANC were excluded since they had no previous pregnancy and child experiences that could help researcher to establish whether they received or not received support in pregnancy and childbirth. Single mothers were also excluded.

3.6 Research instruments.

The study employed semi-structured questionnaire. Semi-structured questionnaires with both open and close ended questions were administered to mothers. The questionnaire was an appropriate tool for scientifically eliciting mothers' experiences on their male support received during pregnancy and childbirth. The tool used was to structure the questionnaires was adapted from study done on male support for family planning and modern contraceptive use in Luanda, Angola (Prata et al 2017).

3.7 Quality Control

Data was checked for completeness and consistency, and validity. Data was organized in five stages, organization of the data, dissembling the data, reassembling data interpreting and drawing conclusion. (Yin, 2011). Interpretation was done by constantly making comparisons within a local and wider context. Raw data was stored under lock and key and would be destroyed after three years to avoid concocted data. Both hard copies and soft copies would only be accessed by specific people allowed to access it.

3.8 Study tools/Measurements

Factors associated with male partner support included social demographic factors such as marital status , age, spouse knowledge on pregnancy needs and dangers, education level , occupation, history of pregnancy complications, type of marriage , religion, number of children , the social cultural factors included gender norms and values, traditional approaches to antenatal care while health facility factors included behaviour and language use by health care workers, venue and space constraints for men , waiting time , quality of

care, gender distribution of staff , health service provider attitude and commitment , distance to the facility and lack of privacy for men.

Male partner support was assessed using questions that elicited the participant's financial, physical, emotional, communicational /informational and decision-making support that were received from their partners. The tool used was adopted from study done on male support for family planning and modern contraceptive use in Luanda, Angola (Prata et al 2017). To get the overall support, the total score was summed for financial assistance, physical support, emotional support, communicational /informational support and decision-making support,

3.9 Management and Data Analysis

Data collected was exported into Stata (version 15) for analysis. For objective one and two, descriptive statistics of frequencies and percentages were used in getting the proportion of women who received the various types of financial, physical, emotional, and communicational and decision-making support.

For objective two, total score of male partner support, was categorized into a binary variable of high support and low support i.e. score less than 99 was recoded as 0 (low support) and a score of 99 and above recoded as 1 (high support).

For objective three, we used logistics regression for crude odds ratio at 0.05 level of significance to determine the factors associated with male partner support and variables statistically significant were further analyzed at a multivariable level using logistics regression for adjusted odds ratio at a 0.05 level of significance while controlling for the biologically plausible variables of marital status, age and type of marriage.

3.10 Ethical Considerations

Ethical clearance to conduct this study was sought from Mbarara University of Science and Technology (MUST -REC). Administrative permission was sought from department of community health for the intent to conduct data collection. A copy of it was presented to the district Health office for signing and permission was granted to go to facilities and conduct study. Written informed consent was presented to all participants and sought their consent before participation. Participants were informed of no risk to their participation. They were also assured of total confidentiality and their participation was voluntary with right to withdraw their participation at any time during interview. Study participants were informed of no effect or harm for their refusal or non-participation in the study and their participation was solely for academic purpose.

3.11 Limitations of the Study

Selection bias: The study was not all inclusive of all eligible participants (mothers)

The study employed cross-sectional design. Cross sectional design cannot confirm causation.

3.12. Dissemination plan

Results from this study will be published in an international recognized peer reviewed journal to building a base for further research.

A copy of this dissertation will be stored at Kabale University library, and other copies distributed to District Health office- Kabale, and facility heads.

CHAPTER FOUR

STUDY RESULTS

4.0 Introduction

The study determined the factors affecting male partner support during pregnancy and child birth in selected health facilities in Kabale district. All 318 questionnaires for mothers were administered, representing 100 percent response rate. Results are presented according to study objectives. Socio - demographic characteristics were defined in terms of age, occupation, education, religion Marital status, types of Marriage, number of children, history of pregnancy and child birth problems, distance to the nearby health facility district of residence and name of the health facility where the woman attended antenatal delivery. The proportion of women who received support during pregnancy and child birth was described in terms of Financial, physical, emotional communicational information and decision making. In addition, the findings present the level of support given by male partners and finally the factors that influence male partner support during pregnancy and childbirth described in terms of individual, socio-cultural and health facility level factors.

4.1 Demographic Characteristics of the Study Participants

Data was collected from total of 318 who had attended antenatal and postnatal mothers in the four selected health facilities. The response rate was 100 percent. Demographically, most mothers studied were between 25 and 35 years, representing 175 (55 %). In terms of occupation, many of the mothers studied were self -employed in business, farming, craft and trading representing 279 (87.7%). The majority of the mothers had either attained primary or secondary level representing 219 (68.9 %,)). Almost all mothers studied were Christians representing 299 (94%) while about 219 (68.9%), majority were married 310 (97, 5%), a higher number 219(68.9%) had history of pregnancy and child birth problems. Majority of the mothers were from monogamous marriages 281(88.4 %) and about 193 (60.7 %) resided in less than 5 kilometres. Detailed information was presented (in table 2 below).

Table 2 Descriptive statistics of the Participants (318)

Study Variables	Options	Freq	%
Age Group	15-24	91	28.6
	25-35	175	55
	36-49	52	16.4
Occupation	Public Servant	25	7.9
	Self Employed (Business, farming, craft, trading)	279	87.7
	Others	14	4.4
Educational Status	No formal Education	30	9.4
	Primary / Secondary Level	219	68.9
	Higher Education	69	21.7
	Christian (Anglican, Born Again,	299	94
Religion	Catholic)		
	None Christian	19	6.0
Marital Status	Married	310	97.5
	Widowed	8	2.5
Type of marriage	Monogamous	281	88.4
	Polygamous	37	11.6
Number of children	1 - 3 Children	233	73.3
	3 and above	85	26.7
History of pregnancy& child birth	Yes	219	68.9
problems	No	99	31.1
Distance to the Facility	≤5kms	193	60.7
	6-10 kms	82	25.8
	>10 kms	43	13.5

The health facility where the woman attended antenatal delivery

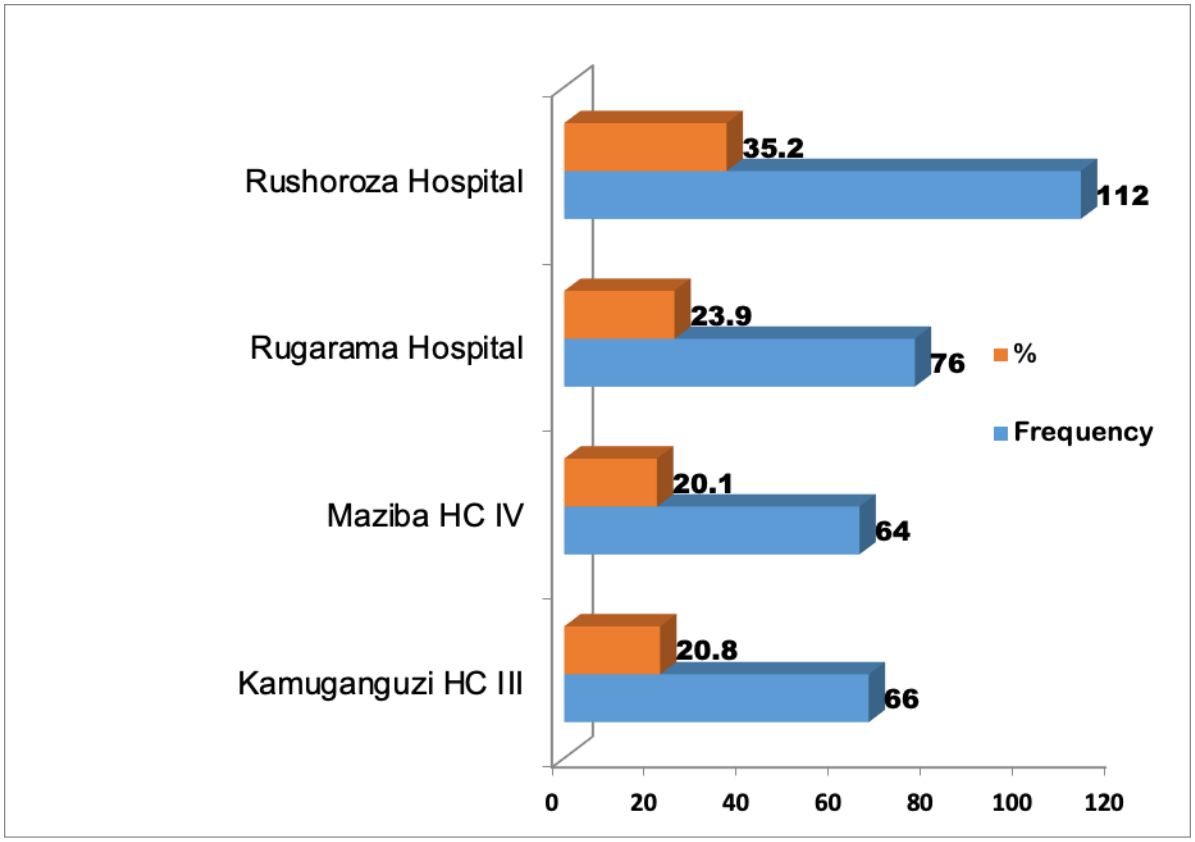

Figure 3: Health facilities attended for ANC services

Study findings from the distribution of health facilities the respondents attended, the numbers differed by proportionate sample disaggregation depending on antenatal visits captured in the April - September 2021 roll out. As such the majority of respondent to that effect were from Rushoroza hospital as presented in the figure (3) above.

4.2 Proportion of women who received male support during pregnancy and child birth in selected health facilities

The study findings show that on average , a total of 238 (74.9%) received financial support from their male partners during pregnancy and child birth, the most aspect of financial support was purchase of medication and payment of bills 263(82.7%), followed by financial offer for food 257 (80.8) and saving money aside during pregnancy and childbirth 254(79.9%). The total average number of women who received physical support were 194 (61%), the most aspect of physical support was husband's presence during labour and childbirth 251(78.9), followed by transporting her to health facility 248 (77.9) and participation in new born care (61.9%). The total average number of women who received emotional support were 229(72%), the highest number of women 257(80.8%) received

love, empathy and care during time of pain, 253(79.5%) receiving love, care and empathy through pregnancy period, and 252 (79.2%) received understanding from their husbands on what they were going through in pregnancy and childbirth. The total average number of women who received communication support was 203 (63.8%), the highest aspect of communication support received being communicating to them about place of delivery 248 (77.9%) followed by encouragement to take prescribed drugs and discussion of maternal health issues 225 (70.7%). The average total number of women who received decision making were 181(57%), the most aspect of decision making received on decision making on place of delivery 242 (76.1%), followed by assisting in planning to seek for care 239 (75.1 %) and decision on the place of birth 191 (60%). (Table 3)

Table 3 Proportion of women who received the various support (n = 318)

Type of support received by mothers/women.	**No of mothers who received support**	**%**
Financial Support		
Husband bought medication and Pays bills	263	82.7
Saved money aside during pregnancy and childbirths	254	79.9
Husband gave me financial support when I ask for it for food	257	80.8
Took me or baby to hospital whenever the need arises (Paid for transportation)	249	78.3
Helped me to prepare and save money for ANC visits and delivery	212	66.6
Average percentage of financial support	**238**	**74.9%**
Physical support		
Husband always accompanied me to hospital during ANC	149	46.9
Assisted me at home for house hold tasks	147	46.2
Provided and prepared nutritious meals during pregnancy	205	64.4
Provided for transportation to the health facility	248	77.9
Participated in the antenatal care consultation	156	49.
Was present during labour and childbirth	251	78.9
Took care of the newly born baby	196	61.6
Participated in the first new born antenatal care.	197	61.9
Average percentage of physical support	**194**	**61%**

Emotional support

Showed love, empathy and caring when I was in pain	257	80.8
He was understanding of my situation during pregnancy	252	79.2
Expressed love, care and empathy during pregnancy	253	79.5
Was encouraging	243	76.4
Was always there for me.	226	71
Joined medical queues for me.	143	44.9
Average percentage of emotional support	**229**	**72%**

Communication support

Discussed maternal health issues with me	217	68.2
Encouraged me to take prescribed drugs	225	70.7
Helped me in preparing birth plan	206	64.7
Husband discussed with health care providers about my pregnancy and childbirth status.	166	52.2
Discussed with me on about what happens during ANC	198	62.2
Communicated with me about the place of delivery.	248	77.9
Shared with me information about postnatal care	169	53.1
We discussed together about birth preparedness and complication readiness plans.	196	61.6
Average percentage of communication support.	**203**	**63.8%**

Decision making support

Assisted in planning for seeking care.	239	75.1
Decision making for place for delivery.	242	76.1
He is the one who took the decision for to go to antenatal care.	146	49.9
He is the one who decided on the place of birth	191	60.0
He is the one who took the decision to go for new born care	145	45.6
He is the one who decided that we go for postnatal care	124	39
Total percentage support of decion making support	**181**	**57%**

Overall proportion of women who received male partner support were 216/318 representing 68%

4.3 Level of men's support were received during pregnancy and childbirth

From the study findings, majority of the participants 205(64%) received high financial support, 59(19%) received low financial support while only 54(17%) received moderate financial support.

The majority of the participants 129(41%) received low physical support, 119(37%) had moderate physical support and only 70(22%) received high physical support.

The majority of the participants 142(45%) received high emotional support, 107(34%) had moderate physical support and only 69(22%) had low emotional support.

Majority of the participants 160(50%) received moderate communication support, 92(29%) received Low Communication Support while 65(21%) received High Communication Support

Of the 318 participants, Women who received high decision-making support were 131(41%) similar to those who received low decision-making support and only 56(18%) received moderate support see (Table 4)

Table 4 Level of men's Support (n=318)

Study variable	Freq.	Percent
Financial Support		
High support	205	64
Moderate	54	17
Low support	59	19
Physical Support		
High support	70	22
Moderate	119	37
High Support	129	41
Emotional Support		
High Support	142	45
Moderate	107	34
Low support	69	21
Communication Support		

High support	65	21
Moderate	160	50
Low support	92	29
Decision Making		
High support	131	41
Moderate	56	18
Low	131	41

4.4.0 Factors associated with male partner support

4.4.1 Bivariate Analysis of factors associated with male partner support

Results from bivariate analysis showed a significant association between health-related factors and support women received from their male partners (OR=1.16, 95%CI: 1.08 to 1.25, p<0.001). Contextual / Social cultural related factors were also significantly associated with support women received from their male partners (OR=1.19 95%CI: 1.03 to 1.38, p=0.017). Details in Table 5.

Table 5 Factors associated with Male partners support during pregnancy and child birth

	Male partners support during pregnancy and child birth			
Study Variables	cOR	p-value	95% CI	
Age Group			LCI	UCI
15-24	ref			
25-35	0.72	0.229	0.42	1.23
36-49	1.25	0.534	0.62	2.52
Occupation				
Public Servant	ref			
Self Employed	0.99	0.992	0.41	2.39
Others	1.18	0.813	0.30	4.69
Educational Status				
No formal Education	Ref			
Primary / Secondary Level	0.90	0.806	0.39	2.08
Higher Education	2.02	0.132	0.81	5.03

Religion				
Christian	Ref			
None Christian	0.55	0.295	0.18	1.69
Marital Status				
Married	Ref			
Single	0.70	0.666	0.14	3.53
Type of marriage				
Monogamous	Ref			
Polygamous	0.76	0.485	0.35	1.64
Number of children				
1 - 3 Children	Ref			
3 and above	1.41	0.200	0.84	2.37
History of pregnancy& child birth problems				
Yes	Ref			
No	0.86	0.560	0.52	1.43
Distance to the Facility				
≤5kms	Ref			
6-10 kms	0.82	0.497	0.47	1.44
>10 kms	0.57	0.151	0.26	1.23
Individual Related Factors, Total Score	1.04	0.374	0.95	1.14
Health related factors, total score	1.16	<0.001	1.08	1.25
Contextual / Social cultural related factors, Total Score	1.19	0.017	1.03	1.38

Note: cOR=Crude odds ratio, p= probability value at 0.05 level of significance**,** CI=95% Confidence Interval

4.4.2 Association between Male partners support during pregnancy and child birth and its predictors

A logistic regression was run with a binary variable (male partners support during pregnancy and child birth) as a dependent variable and health related factors and contextual/social cultural related factors as predictors since they were significant at a bivariate analysis while controlling for marital status, type of marriage and age.

The model was of a good fit (likelihood chi-square 21.05) is statistically significant (p=0.0018).

High score of women on health related factors was associated with high odds of male partners support during pregnancy and child birth (OR=1.15, 95%CI: 1.06 to 1.25, p=0.001). Details table 6

Table 6 Association between Male partners support during pregnancy and child birth and its predictors

	Male partners support during pregnancy and child birth			
Study Variables	OR	p-value	95% CI	
Age group			LCI	UCI
15-24	ref			
25-35	0.78	0.396	0.44	1.38
36-49	1.26	0.538	0.61	2.61
Marital_status				
Married	Ref			
Single	0.53	0.464	0.10	2.88
Type_Marriage				
Monogamous	Ref			
Polygamous	0.71	0.396	0.32	1.57
Health Related Factors, Total Score	1.15	0.001	1.06	1.25
Contextual / Social cultural related factors, Total Score	1.03	0.778	0.86	1.22

Note: OR=Crude odds ratio, p= probability value at 0.05 level of significance**,** CI=95% Confidence Interval

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.0 INTRODUCTION

This chapter provides a discussion of the results of the study d the application and interpretation of the theories used to the understanding of results in line with study objectives, summary, conclusion and recommendations regarding the study

5.1 Discussion of Results

5.1.1 Proportion of women receiving male partner support

The study findings on the average support received by the study respondents during pregnancy and child's birth showed that a total of 238 (74.9%) received financial support. 194 (61%) received physical support, 229(72) received emotional support, 203 (63.8%) received communication support and 181(57%) received decision making support.

Relating to study done by Zakaria in urban slum areas of Bangladesh (Zakaria et al., 2021), this study highlighted a higher level of male support compared to support received by women in Bangaldesh in similar slum urban setting . Comparing the number of men accompanying their spouse in this study to Kabanga's hospital based cross-sectional study undertaken in Kyela district-Mbeya in Tanzania (Kabanga et al., 2019), there is considerable low male partner support in aspect of men accompanying their spouse to ANC in Kabale district, both Kabale and Kyela district are rural based districts and therefore, the findings are tailored from same settings. In terms of joint decisions, only 57.6 percent of women in this study presented receiving decision making support from their male partners during pregnancy and childbirth, relating to similar study conducted in Dodoma Region, Central Tanzania by Gibore (Gibore et al., 2019) its found out that male partner support in terms of decision making was low in Kabale- Uganda. Similarly, the rate of physical support in this study was low at 61% compared to 77.3% reported by Gibore's study findings in Tanzania, however, there is noted difference in study setting with Gibore's study being urban based in central region of Tanzania and as such being urban, certain factors different from Kabale – a rural district could have facilitated male partner performance in the area.

5.1.2 Level of men's support received during pregnancy and childbirth.

The study findings on level of support found out that majority of the participants received high financial support, low physical support, high emotional support, moderate communication support while women who received high decision-making support were similar to those who received low decision-making support.

5.1.3 Factors associated male partner support during pregnancy and child births

The study results found that health facility related factors and contextual/social cultural related factors were significantly associated with support women received from their partners

A logistic regression run with a binary variable (male partners support during pregnance and child birth) as a dependent variable and health related factors and contextual/social cultural related factors also showed a high score of health facility related factors assocoiated with high odds of male partners support during pregnancy and childbirth

The study resulst coincides with Kura's study (Kura et al., 2013) which reported that male partners' poor knowledge, socio-cultural factors hampered the utilization of health services by pregnant wives. Similarly, findings relate to study by Kariuki and Seruwagi, (Kariuki & Seruwagi, 2016) which attributed low male involvement to socio-demographic factors such as education, marriage and lower income status to decrease male support, the findings also relate to Gibore et al.,2019 study findings which indicated religion, occupation, ethnicity, waiting time to significantly influence men's support. Village life influences were reported to significantly influence male support in this study, this is similar to what Helleve reported in his study that men who escorted their partners were subjected to gossip by their male counterparts (Helleve, 2010). Working long distance from home, peer group influence, alcoholism, Polygamy, Fear to test for HIV/AIDs when they go to the facility, Poverty (Low income to support family, Ignorance on men's roles and responsibilities and benefits of their support also affect male support.

5.2 Conclusion

The study found that most women received some form of support .The commonest forms of support were financial and emotional as opposed to physical, communication and decision making support. Health facility related factors and socio- cultural factors had the biggest effect on male partner support for women during pregnancy and child birth.

5.3 Recommendations

From the study findings, it is recommended that the Health ministry and district officials should ensure that health facilities' environment has adequate provision for men.

Design interventions to popularize male support for pregnant partners.

Develop incentive interventions to encourage men who already support female partners.

Recruit and train male champions for partner support as peer educators.

Adopt and enforce resource package engaging men in pregnancy and childbirth.

5.4 Suggestion for further studies

1) Further studies are encouraged on assessing male partner support in post-natal care.
2) Health facility factors associated with maternal deaths in Kigezi region.
3) Determining the adoption, compliance and performance of ANC on new WHO guidelines for 8 ANC visits.

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APPENDICES

APPENDIX I:

APPENDIX I (a): INFORMED CONSENT ENGLISH

MBARARA UNIVERSITY OF SCIENCE AND TECHNOLOGY

RESEARCH ETHICS COMMITTEE

P.O. Box 1410 Mbarara, Tel: +256-48-543-3795, Fax: +256-48-542-0782

E-mail: irc@must.ac.ug, mustirb@gmail.com

INFORMED CONSENT

This document outlines the research study and expectations for potential participants. It should be written in layman terms and typed on MUST-REC letterhead.

Instructions

1. The wording of this document should be directed to the potential participant not MUST-REC.
2. If a technical term must be used, then define it the first time it is used and any acronyms or abbreviations used should be spelled out the first time they are used.
3. All the sections of this document must be completed without any editing or deletions.
4. Please use a typing font that is easily distinguishable from the questions of this form. Preferably the font size should be 12.

Study title – This should be the same as on all other documents related to the study.

Factors affecting male partner support during pregnancy and childbirth in Selected Health Facilities in Kabale District.

Principal Investigator(s)

Niwarinda Denesi Kabale University.

Introduction

What you should know about this study:

1. You ar e being asked to join a research study
2. This consent form explains the research study and your part in the study.
3. Please read it carefully and take as much time as you need.
4. You are a volunteer. You can choose not to take part and if you join, you may quit at any time. There will be no penalty if you decide to quit the study.

Brief background to the study

Developing countries still suffer from a large number of maternal deaths and pregnancy and child birth have been regarded risk events in women's lives. Maternal mortality presents a global health problem with an estimated 295000 women and adolescent girls dying as a result of pregnancy and child related complications worldwide. In Uganda every day, 20 mothers die from preventable causes of pregnancy and childbirths. Evidence from written literature indicate that male support during pregnancy and childbirth plays a key role in reducing and preventing pregnancy and childbirths problems and can reduce maternal and child death rates.

This study therefore investigates the factors that affect male partner support during pregnancy and childbirth in selected health facilities in Kabale District.

Purpose of the research project.

Include a statement that the study involves research, estimated number of participants, an explanation of the purpose(s) of the research procedure and the expected duration of the subject's participation.

The purpose of this study is to investigate factors affecting male partner support during pregnancy and child birth in selected health facilities in Kabale district. The study will last for one month but answering the questions in this questionnaire will take about 30 minutes. The results of this study will help the researcher to fulfill his academic requirement and will inform every stakeholder to design and participate in programs and interventions aimed at improving pregnancy and child birth outcomes and consequently reduce pregnancy and child birth deaths.

Why you are being asked to participate?

Explain why you have selected the individual to participate in the study.

You are one of 318 selected people to participate in this study to help in improving the health of pregnant mothers and those giving birth in Uganda and Kabale specifically. You have been selected because you meet the eligibility undertaken in this study for selection in this study because you are a woman of reproductive age 15-49 and you have experiences regarding pregnancy and child birth experiences because you are a mother, and thus you have a lot you can share with us

Procedures

Provide a description of the procedures to be followed and identification of any procedures that are experimental, clinical etc. If there is need for storage of biological (body) specimens, explain why, and include a statement requesting for consent to store the specimens and state the duration of storage.

This study was approved by Mbarara University of Science and Technology - Research Ethics Committee (MUST REC).

Participating in this study is voluntary. You have the right to choose not to respond to questions that may make you feel uncomfortable. You can tell the researcher of your inability to respond to certain questions where you feel uncomfortable so that you move on to the next question.

Risks or discomforts

Describe any reasonably foreseeable risks or discomforts-physical, psychological, social, legal or other associated with the procedure, and include information about their likelihood and seriousness. Discuss the procedures for protecting against or minimizing any potential risks to the subject. Discuss the risks in relation to the anticipated benefits to the subjects and to society.

The questions in this questionnaire may make you feel uncomfortable, and make you feel risking your relationship with your husband. But the questions posed in this questionnaire are neither harmful in any way to your relationship nor can they implicate your husband in any matters concerning whether he supports and cares for you or not. The response given will not

be harmful to you in any way. Your information will be kept privately and your name will not be disclosed to any other person apart from the research team. In case you find that a certain question makes you feel uncomfortable, you have the right to skip it to the next.

Benefits

Describe any benefits to the subject or other benefits that may reasonably be expected from the research. If the subject is not likely to benefit personally from the experimental protocol note this in the statement of benefits.

You will not be paid for participating in this study but we shall appreciate you for your role in contributing knowledge aimed at improving lives of mothers during pregnancy and childbirth and reducing maternal and child deaths for women like you in future.

Incentives or rewards for participating

It is assumed that there are no costs to subjects enrolled in research protocols. Any payments to be made to the subject, e.g., travel expenses, token of appreciation for time spent, must also be stated, including when the payment will be made.

You will not receive any compensation or reward for participating in this study because participation in this study is voluntary, but we shall appreciate you for your participation.

Protecting data confidentiality

Provide a statement describing the extent, if any, to which confidentiality or records identifying the subjects will be maintained. If data is in form of tape recordings, photographs, movies or videotapes, researcher should describe period of time they will be retained before destruction. Showing or playing of such data must be disclosed, including instructional purposes.

The researcher will ensure that whatever answers you give him are confidential and will not be shared or disclosed to any person that is not concerned. Your name will not be disclosed in any documents or reports from this research rather, we shall assign codes to represent participants in study results and reports.

Protecting subject privacy during data collection

Describe how the privacy of the participant will be ensured during the process of data collection.

Your information will be kept with utmost confidentiality.
The responses obtained from you will be kept secret. You will not write your name or your husband's name on this questionnaire. You will not be personally liable for your responses in this research. We shall capture your details but we shall assign a code to you that we shall use not your name. All the information written on study report will be treated with confidentiality.

Right to refuse or withdraw

Include a statement that participation is voluntary and that refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled. Taking part in this study is voluntary.

Taking part in the study is your choice. You can decide to or not to take part in the study and have the right to withdraw at any point during interview or survey.

What happens if you leave the study?
Include a statement that the subject may discontinue participation at any time without penalty or loss of benefits.

In case you change your mind amidst the interview or survey during the study and feel not to continue taking part, you are free to stop. There is no penalty if you decide to stop after you have begun participating.

Who do I ask/call if I have questions or a problem?
Include contact for the researcher and Chairperson, MUST-REC.

If you have questions about the research, you may contact Mr. Niwarinda Denesi- Research Principal Investigator at Tel: 0784269235 /0751935694

If you have any concerns about your rights in this research, please contact the MUST-IRB office: Dr. Francis Bajunirwe, Chairman MUST REC, P.O Box 1410, Mbarara,

Tel. 0485433795/077257396

What does your signature or thumbprint on this consent form mean?

Your signature on this form means

- You have been informed about this study's purpose, procedures, possible benefits and risks
- You have been given the chance to ask questions before you sign
- You have voluntarily agreed to be in this study

_ _

Name of adult participant Signature/Thumbprint of participant/ Date

Parent/Guardian/Next of Kin

_ _

Name of person obtaining consent Signature Date

_ ________

Print Name of witness Signature or thumbprint or mark Date

APPENDIX I (b):

INFORMED CONSENT: RUKIGA/RUNYANKORE.

MBARARA UNIVERSITY OF SCIENCE AND TECHNOLOGY

RESEARCH ETHICS COMMITTEE

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E-mail: irc@must.ac.ug, mustirb@gmail.com

INFORMED CONSENT / EKIHANDIIKO KY'OKWIKIRIZA KUMBUUZA

Omutwe gwekyokucondoozaho

Enshonga ezirikukwata ahabuhwezi n'endebereera yabasheija ahabakazi babo baba bein'enda n'omukazara omumagwariro agatworeinwe mu Kabale disiturikiti

Principal Investigator(s) (Omucondoozi Mukuru)

Niwarinda Denesi

Kabale University.

Okwanjura:

Ebyoshemereire Kumanya ahakukyondoza oku.

- Noshabwa kwejumbira Omucondooza oku.
- Ekihandiko eki nikishoborora Omucondooza okuriyo nikukorwa hamwe nokworakwejumbiremu.
- Noshabwa kushoma ekihandiko eki nobwegyendesereza kandi okatwara obwire obworikwetaga
- Ori nyekundeire; nobaasa kusharamu obutikiriza kukyondozibwa kandi kuwakwikiriza kukyondozibwa, eshaha yoona nobaasa kurugamu ahorayendere. Tiharikwija kukubaho ekiheneso kyona kuwakusharamu kwanga kucondoozibwa

Leave blank for REC office only:	REC OFFICE USE ONLY:
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Enturukiriro y'okucondooza omubugufu.

Abakazi bingi nibafa munonga baba beine enda nababa nibazaara omumahanga agakyirikukurakurana kandi okugire'enda, nanokuzaara nibitwazibwa nkebyokwerarikiriza munonga ahamgara gabakazi. Omunsi yoona, abakazi nabishiki barikwejumba emitwaro abiri na mwenda (295000) nibafa ahabwobuzibu burikurugirira omukugirenda nanokuzaara. Omwihanga ryeitu erya-Uganda, burizooba, abakazi 20 nibafa barikweitwa eshonga zirikurugirira omukuzaara ezokubire zirikwerindwa. Okucondooza okwakozirweho abandi bacondoozi nikworeka ngu obuwhezi, n'endebereera ya banyeineka abasheija nikuhwera kihango, omukukyendeza no kwihaho oburemezi nakabi aku abakazi babo barikubasa kugira baba bein'enda hamwe nan'omukuzaara kandi eki kikakyendeza omubaro bwa bakazi barikufa bein'enda nan'omukuzara. Nitucondoza enshonga ezirikukwata ahabuhwezi n'endebereera yabasheija ahabakazi babo baba bein'enda n'omukazara omumagwariro agatworeinwe mu Kabale disiturikiti.

Omugasho gw'oku Okucondooza oku?

Ekigyendererwa ky'okucondooza n'okwenda kumanya enshonga ezirikukwata ahabuhwezi n'endebereera yabasheija ahabakazi babo baba bein'enda n'omukazaara omumagwariro agatworeinwe mu Kabale disiturikiti. Okucondooza oku nikuza kutwara obwire bw'okwezi Kumwe kwonka ebibuzo nibiza kutwara endakiika makumi ashatu. Ebiraaruge omukucondooza ogu nibizakuyamba omuryokushooma kworikucondooza kandi biyambe buri'omwe owukirikukwataho weena omukutaho enkora, nanokwejumbira muntebekanisa zo kwongyera omutindo rwamagara gabakazi abarikuzaara nabeinenda kucenderezakimwe okufa kwabakazi bein'enda nabarikuzaara.

Nahabwenki Orikushabwa kwejumbira omukucondooza oku?

Otoraimwe Kwejumbira omukucondooza nkomwe ahabakazi bokuganiira n'okuhajaana aha nshonga ezirikukwata ahabuhwezi n'endebereera yabasheija ahabakazi babo baba bein'enda n'omukazaara omumagwariro agatworeinwe mu Kabale disiturikiti. Kwejumbira omukucondooza oku nikuza kuyambaho okwongyera omutindo gwa magara ga abakazi abeinenda nabarikuzaara omu Uganda kandi na Kabale. Otoreinwe ahabwokuba ohikirize ebintu ebitugyendeireho kutoorana omuntu weena kwejumbira omukucondooza oku ahakuba ori omukazi wenyaaka eryahagati yei'kumi netaano na makumi ana na mwenda kandi watungireho obumanyirivu nebikwatanirine nenda hamwe nokuzaara ahakuba, ori'omuzeire.

Entwaza

Okucondooza oku kuhinguziibwe kandi kwahamibwa abeitendekyero rikuru rya Mbarara erya Sayansa hamwe na tekinorogiya n'abakakiiko k'engyesho z'abantu (MUST REC).

- Oine obugabe kweshariramu obutagagarukamu. Kwejumbira omukucondooza oku nokwekundira.
- Oine obugabe kurekyeraho eshaha yoona okugarukamu otashobororeire ahabwenki, kwonka ninza

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kushemereerwa kuwakugumizamu okamara ekigaaniro. Ebiturabagane nituza kubiha enamba kwita akakwate karyo na maziina gorikuba yabigambire.

Ebintu ebyakukuretera okutiina ninga otaberwa kurungi

Ebibuzo ebiturikuza kubaganaho omuri'ekikigaaniro nibibasa kutuma otaberwagye ahabikwatirine nomukaago ogwoine nomukundwa wawe. Kwihaho, ebibuzo tiryokurabanisamu mbera yo mukundwa wawe ngu obundi takukuhwera nokukureberera kandi tihiine kukirabe kyakabi ahariwe ninga iwe. Ebiturabaganeho nibiza kubikwa nkebihama kandi ebikukwasireho nkamaziina nesiimu tibirikwija kushururwa ahantu hoona. Kandi kuwakushanga ngu ekibuuzo kananka tikirikukoragye, noikirizibwa obutakigarukamu.

Ebyokufuna omukucondooza oku.
Tihariho okushashurwa kwoona okurabeho ahabwokwejumbira omukucondooza oku kwonka nituza kukwebaza munonga ahabwenterero
yawe omukucondooza oku nokwongyera omutindo rwabakazi beinenda nabarikuzara, kucendeeza nokwihaho okufa kwabakazi nkeiwe.
Akasiimo ningashi ebirabo ahabwokwejumbira omukucondooza.
Tihariho akasiimo koona akitwakukuhereza ahabwokwejumbira omukukucondooza oku ahakuba okwejumbiramu kwawe nokwekundira kwonka nitukusiima munonga ahabwokwejumbira omukucondooza oku.
Okukuuma ebihama byawe
Omucondoozi naza kukuma byoona ebiragambwe kandi tarikuza kubigambira nari kubishururira a bandi bangyenzi bawe ninga omuntu weena owu kitarikukwataho. Amaziina gawe tigarikuza kworekwa ahabihandiko byoona kureka nituza kukoresa enamba zekihama.
Okukuuma ebihama byawe omukucondooza
Ebihama byawe nibiza kukumwagye munonga. Ebyoramugambe byoona ninga ebihama byawe tihiine orikubaasa kubimanya. Torikuza kuta eizina ryawe nari ebyo musheija wawe ahakihandiko kyokuburizaho torikwija kubarigwaho nkomuntu ebyoratugambire. Nituza kubaganaho ahabirikukutwataho kwonka nituza kukozesa enamba zekihama ritari eizina ryawe. Ebyoratugambire byoona, nebiturahandike byoona nibiza kukumwagye munonga omukihama.

Obugabe bwo'kwanga ninga kutamaririza kwejumbira omukucondooza.

Okwejumbiramu omukucondooza oku nokwekundira. Nobaasa kusharamu kukwejumbiramu ninga kutejumbamu kandi oine nobugabe nokwemereza kwejumbiramu hoona ahorayendere waikiriza kwejumbiramu.

Leave blank for REC office only: **MUST-REC Stamp:**	**REC OFFICE USE ONLY:** APPROVAL DATE: 05/04/2022 APPROVED CONSENT IRB VERSION NUMBER: PI NAME: Niwarinda Doresi 2022-04-04 IRB NO: MUST-2022-353

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Nihabahoki washaramu kuruga omukucondooza oku?
Obundi kuwakuhindura ebitekateko ahagati yokubuzibwa nokugarukamu kwawe okahurira otayenda kugumizamu nekihandiko, noikirizibwa obutagumizamu kandi tihariho kifubiro ekyorikuhebwa ahabwokuba wayemereza kandi watandikire kwejumbiramu.

Nimbuz' oha kunakuba nyine ekyokubuza ninga obuzibu?

Kuwakuba oine ekibuuzo nari obuzibu ahabikwatirine Okucondooza oku nohikirira aba;

Omucondooza Mukuru (Principal Investigator)

Mr. Niwarinda Denesi- Omweegi -Kabale University,
Ahasiimu: 0784269235 /0751935694, email: niwarindadenesi@gmail.com.

Kandi kuwakushanga oine eshonga ezirikukwata obugabe bwawe omuri'okukucondooza oku, nyabura ohikirire;
Dr. Francis Bajunirwe, Chairman MUST REC, P.O Box 1410, Mbarara.
Esiimu: 0485433795/077257396, email: fbaj@must.ac.ug

What does your signature or thumbprint on this consent form mean?

Okuteeka omukono ninga ekinkuumu aha fomu egi nikimanyisaki?

Nikimanyisa:

- Wafuna okamunyasibwa ahamugasho gwokucondooza okukurakorwe, okworakugasirwemu hamwe nakabi akarimu.
- Watunga omugisha okubuza ebibuzo otakateireho omukono gwawe.
- Waikiriza oyekundeire kwetaba omukucondooza oku.

Eiziina ryomukuru ori kwejumbira omukucondooza,	Omukono gwowayejumbira, ninga owamujwekyera	Ebirobyokwezi
Eiziina ryowabuza	**Omukono**	**Ebirobyokwezi**
Eiziina ryowabariho	Omukono ninga ekinkuumu	Ebiroryokwezi

Leave blank for REC office only:	REC OFFICE USE ONLY:
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APPENDIX II (A):

QUESTIONNAIRE FOR MOTHERS IN ENGLISH

Questionnaire (To be administered for mothers): English

Section A. Bio-data of the respondent (Social demographic characteristics of respondent).

District of residence..... Sub-county of residence.....

Parish of residence.....Village of residence.....

1. Name of the health facility where the woman attended antenatal delivery.....

Study Participants Demographic Characteristics

Study Question Variables	Options	Tick what applies to you
Age Group of the participant	15-24	
	25-35	
	36-49	
Study Participants' Occupation	Public Servant	
	Self Employed (Business, farming, craft, trading)	
	Others specify ----------	
Educational Status	No formal Education	
	Primary / Secondary Level	
	Higher Education	
Religion	Christian	
	None Christian	
Marital Status	Married	
	Single	
Type of marriage	Monogamous	
	Polygamous	
Number of children	1 - 3 Children	
	3 and above	

History of pregnancy and child birth problems	Yes	
	No	
Distance to the facility.	≤5kms	
	5-10 kms	
	≥10 kms	

What kind /Level of men's support was received during pregnancy and childbirth?

Please Tick; strongly disagree, undecided, strongly agree, agree against each of the questions in relation to men's support received during pregnancy and childbirth

Strongly Disagree 0 , Disagree 1, Undecided 2, Agree 3, Strongly Agree 4						
Study Question Items		**0**	**1**	**2**	**3**	**4**
Financial support	Bought medication and pays bills					
	Saved money aside during pregnancy and childbirths					
	Husband gave me financial support when I ask for it for food					
	Husband helped me in taking care of the baby					
	Took me or baby to hospital whenever the need arises					
	Helped me to prepare and save money for ANC visits and delivery					
Physical support	Husband always accompanied me to hospital during ANC					
	Assisted me at home for house hold tasks					
	Provided and prepared nutritious meals during pregnancy					
	Provided for transportation to the health facility					
	Participated in the antenatal care consultation					
	Was present during labour and childbirth					
	Took care of the newly born baby					
	Participated in the first newborn antenatal care.					

Emotional support	Showed love, empathy and caring when I was in pain					
	He was understanding of my situation during pregnancy					
	Expressed love, care and empathy					
	Was encouraging					
	Was always there for me.					
	Joined medical queues for me.					
Communicational/ informational support.	Discussed maternal health issues with me					
	Encouraged me to take prescribed drugs					
	Helped me in preparing birth plan					
	Husband discussed with health care providers about my pregnancy and childbirth status.					
	Discussed with me on about what happens during ANC					
	Communicated with me about the place of delivery.					
	Shared with me information about postnatal care					
	We discussed together about birth preparedness and complication readiness plans.					
Decision making	Assisted in planning for seeking care.					
	decision making for place for delivery.					
	He is the one who took the decision for to go to antenatal care.					
	He is the one who decided on the place of birth					
	He is the one who took the decision to go for newborn care					
	He is the one who decided that we go for postnatal care					

Others Specify _____

2. **What factors influence male partner support during pregnancy and child birth**

a. Individual related Factors:

Question Items for Individual level factors	**Yes**	**No**
Negative attitude by men		
Perceived appreciation of spouse support in pregnancy and child birth.		
Spouse income status		
Male partners' awareness on the benefit of their support		
Male partner's awareness on danger signs, pregnancy complications and effects		
Perceived knowledge on pregnancy and child birth needs		
Level of education		
Distance from the facility		

Others Specify _____

b. Health Facility related factors:

Question Items for Health facility level factors	**Yes**	**No**
Health facility not making provision for men in Maternal and Childs clinics		
Overcrowding.		
Most services in the health facilities services are provided by female Health care providers		
Long waiting time		
Health Worker attitude and favoring of Females,		
The general health facility does not support and promote men		
The general health facility being unwelcoming, uncooperative and intimidating		
Lack of male partner stated roles and responsibilities.		
Poor behavior and language use		

Venue and space constraints		
Health service provider negative attitude and commitment		
Poor quality of care		

Others Specify _____

c. Contextual / Social cultural related factors.

Question Items for Social cultural related factors.	**Yes**	**No**
Village life influences		
Social prestigious life of men		
Negative perception of society about men engagement in pregnancy and child births.		
Spouses hold on Norms and values		

APPENDIX II (B):

QUESTIONNAIRE FOR MOTHERS IN RUKIGA /RUNYANKORE

Ekihandiiko ky'okubuuza (kwijuzibwa abazaire b'abakazi): Rukiga/Runyankore

Ekikweka eky'okubuuza. Ebirikukwata aha muntu orikugarukamu Okucondooza

Disiturikiti eyarikuturamu .....Egomborora ei arikutuuramu……

Omuruka .....Ekyaaro .....Ebiro by'okwezi……

3. Eizina ry'eirwariro eri waagiremu kucebeza enda, nari okuzaara.....

Emeeza: 6: Ebirikukwata ahabarikucondoozibwa nkabantu.

Ebibuuzo ky'okucondooza	Ebyokutoranamu.	Kyebeera ahu kishemereire.
Emyaaka y'orikucondoozibwaho	15-35	
	36 – 49	
Omurimo gworikucondoozibwaho.	Omukozi wa Gavumenti	
	Nooyekozesa (Omushubuzi, Omuhingi, Ow'ebyemikono)	
	Kuryakuba biri ebindi shoboorora ---------- -	
Obwegyeseza	Tokazagaho omu ishomero	
	Okazaho omu Purayimare	
	Okazaho omu Siniya	
	Okamara siniya yamukaaga	
	Okazaho omu matendekyero amakuru	

	Ebindi---------- -	
Enyikiriza y'orikucondoozibwaho	Ori omukurasi wa Christo	
	Omusiramu	
	Ebindi---------- --	
Ebyobushwere bw'orikucondoozibwaho	Nyine omushaija	
	Nkatana n'omushaija	
	Ndi efaakazi	
	Ndi kyeyombekire	
	Ebindi----------	
Omuringo gw'amaka gw'orikucondoozibwaho	Nshweirwe nyenka	
	Turyabakazi bingi aha mushaija	
Omuhendo rw'abaana	1-3	
	3- nokweyongyerayo	
Yaaba hariho ebyafaayo aha buzibu bwenda na n'okuzaara aha mukazi orikucondoozibwaho.	Eego	
	Ingaaha	
Orugyendo rwokuhika aharwariro.	≤5kms	
	5-10 kms	
	≥10 kms	

Nibuhweziki nendeberera eyiwatungire kuruga ahamusheija wawe obuwabeire oinenda ninga nozara?

Nyabura noshabwa kucebera kimwe ahari ebi: Tinkikirizanira kimwe, Tinkikiriza, tindikumanya, ninykiriza, ninyikiririza kimwe, omumwanya nkoku ebibuzo biri ahabikwatirine n'obuhwezi nanendeberera obu omusheija yakuheire oine enda nan'omukuzara

Ebibuuzo ky'okucondooza		Tinkikiririza kimwe	Tinkikiriza	tindikumanya	Ninykiriza	Ninyikiririza kimwe
Obuhwezi bwa sente.	Akagura emibazi kandi ashashura n'ebishare					
	Akabiika esente aharubaju obu nabeire nyinenda nanomukuzara, akaba ayeterweire.					
	Omushaija wangye kunabeire mushaba obuhwezi bwa'sente akaba azimpa nzakugura ebyokurya ebindikwegomba.					
	Omushaija wangye akanyamba kureberera hamwe nokutebekanisiza abaana					
	Akabantwara ninga atwara omwerere omu irwariro konkukyabeire kyetagisa.					
	Akanyamba omukutebekanisa nanokubiika akasente kokuza kucebeza nanomukuzara					
Obuhwezi bwa kyabandiiho	Omushaija wangye ka buriijo akaba naashendekyereza okuza omu irwariro omu bwire obu naabaire niinkyebeza enda					

	Okumpwera omu kukora emirimo y'omuka					
	Okumpereza n'okutebeekaniisiza ebyokurya birungi ebyombeka amagara omu bwire obu naabaire nyine enda.					
	Okumpeereza entambura y'okutwara aha irwariro					
	Akaba naayeejumbira omu kubuuza n'okucondooza eshonga/ebintu ebikwatiraine n'okucebeza enda					
	Akaba ari naanye omu bwire obu naari aha nda hamwe n'omu bwire bw'okuzaarwa kw'omwana					
	Akatwara obujunaanizibwa bw'okureeberera omwana owaazairwe					
	Akeejumbira omu kuguma arangyenda naanye omu kugyemesa omwana					
Obuhwezi obw'aham utima	Akeereka rukundo, okukwatwaho hamwe n'obuhwezi/obujunaanizibwa omu bwire obu naabaire ndi omu busaasi					
	Akaba ayeetegyereza embera ei naabaire ndimu omu bwire obu naabaire nyine enda					

	Akeereka rukundo, obujunaanizibwa hamwe n'enkwatanisa					
	Akaba nampa hamahama					
	Akaba naaba ariho buri kaire koona ka buriijo					
	Akaba angiira omurunyiriri kunkwatiira emibazi					
Obuhwezi bw'ebyem purizigana /engaaniir a/amakuru agarafa ahabitwet oroire	Okuhanjaana naanye aha nshonga ezikwatiraine n'eby'amagara gangye omu bwire bwenda, okuzaarwa kw'omwana hamwe na bwanyima y'okuzaara					
	Okumpabura omu kurya n'okukoreza emibazi ehamiibwe abashaho					
	Akampwera omu kuteebekanisa n'okweteguriira obwire bw'okuzaara					
	Omushaija wangye akahanjaana n'abashaho ahabikwatiraine n'okugira enda hamwe n'okuzaarwa kw'omwana					
	Akahanjaana naanye aha bikwatiraine n'ebirikubaho omu bwire bw'okucebeza enda					

	Akagaaniira naanye aha bikwatiraine n'omwanya gw'okuzaariramu					
	Akabaganaho naanye aha bikwatiraine n'obuhwezi bw'okureeberera nyowe n'omwana aha nyima y'okuzaara					
	Tukahanjaana hamwe aha kweteegururira okuzaarwa kw'omwana hamwe n'ebyo byona ebyokubaasa kwijamu nk'ebirwererezi					
Okukora ensharamu	Akampwera omu kutebeekanisa okuronda obuhwezi					
	Ensharamu y'okutoorana omwanya gw'okuzaariramu					
	Niwe yaashaziremu/yaaretsire ekiteekateeko ky'okuza kucebeza enda.					
	Niwe yaaretsire ekiteekateeko ky'okutwara omwana kugyemeesibwa					
	Niwe yaashaziremu ngu tuze kubuuza aha bikwatiraine n'obuhwezi bw'okureeberera nyowe n'omwana aha nyima y'okuzaara					

Hookuba hariho ebindi ebi eryorikumanya, byoreke aha

_____

4. **Ni nshonga ki ezikwatiraine n'obuhwezi hamwe n'obujunaanizibwa bw'omushaija aha mukazi we yaaba aine enda hamwe n'omu bwire bw'okuzaarwa kw'omwana?**

d. Eshonga eziine akakwate n'omuntu buntu:

Enkarara z'ebibuuzo ebikwatiraine n'eshonga eziine akakwate n'omuntu buntu	**Eego**	**Ingaaha**
Enteekateeka mbi ya/omu bashaija		
Omuhwezi/omukundwa/omurigirwa okusiima obuhwezi n'obuyambi omu bwire bw'enda n'omubwire bw'okuzaarwa kw'omwana		
Ororengo gw'entaasya y'omuhwezi/omukundwa/omurigirwa		
Omushaija okumanya ebirungi ebiri omu by'obuhwezi n'obujunaanizibwa		
Omushaija okumanya obumanyiso obutabonaire, ebirwererezi ebirabaho aha mukazi w'enda hamwe n'ebirazaarurukamu		
Okwetegyereeza ebikwatiraine n'enda hamwe n'ebyetengo ebiretaarwa aha kuzaarwa kw'omwana		
Idaara ry'eby'obwegyese		
Oburaingwa bw'orugyendo gw'okuruga aha irwariro		

Hookuba hariho ebindi ebi oramanya, byoreke

_____

e. Enshonga eziine akakwate n'omwanya gw'okujaanjaabirwamu (eirwariro):

Enkarara z'ebibuuzo ebikwatiraine n'eshonga eziine akakwate n'omwanya gw'okujaajaabirwamu (eirwariro)	**Eego**	**Ingaaha**
Emyanya y'okujaajaabirwamu (eirwariro) nk'emyanya y'abakazi abaine enda hamwe n'omu marwariro g'abaana obutaheereza abashaija ebyetaago		
Omwijurirano gw'abantu omu marwariro		
Obuheereza oburakira obwingi omu marwariro buraheerezibwayo abashaho b'abakazi		

Okumara omwanya muraingwa omu irwariro oteegyereize obuheereza bw'abashaho		
Abakozi b'eby'amagara okwebembeza ekintu ky'okuhwera abakazi okukira abashaija		
Eirwariro ryona okutwarira hamwe tirirahwera abashaija hamwe n'okubahagira		
Eirwariro ryona okutwrira hamwe tirirakiira, tirirakwatanisa hamwe n'okutiinisiriza		
Obutagira orukarara rurooreka emirimo n'obujunaanizibwa bw'omushaija.		
Emicwe mibi hamwe n'okukoresa kubi orurimi kwabashaho.		
Emyanya hamwe n'okugira emyanya etaramara.		
Abakozi b'eby'amagara okugira enteekateeka mbi hamwe n'obuteehayo		
Okubura obuheereza		

Hookuba hariho ebindi ebi oramanya, byoreke aha

_____

f. Enshonga eziine akakwate n'emibaireho/entuura y'abantu hamwe n'eby'obuhangwa

Enkarara z'ebibuuzo ebikwatiraine n'eshonga eziine akakwate n'emibaireho/entuura y'abantu hamwe n'eby'obuhangwa	**Eego**	**Ingaaha**
Enshonga y'embera y'ekyaaro		
Ekitiinisa ky'abashaija omu mituriire yaabo		
Enteekateeka mbi y'abantu omu kyanga aha bashaija omu kwejumbira omu bintu by'enda z'abakazi hamwe n'okuzaarwa kw'abaana		
Abakundaine (omushaija n'omukazi) okwemarira omu migyenzo hamwe n'ebiragiro by'eby'obuhangwa (obunyakare)		

APPENDIX III

RECOMMDENDATION LETTER TO MBARARA REC

DEPARTMENT OF COMMUNITY HEALTH

KABALE UNIVERSITY
P.O Box 317
Kabale - Uganda
Email: info@kab.ac.ug
admissions@kab.ac.ug

Tel: 256-392-848355/04864-26463
Mob: 256-782860259
Fax: 256-4864-22803
Website: www.kab.ac.ug

DEPARTMENT OF COMMUNITY HEALTH

KABALE SCHOOL OF MEDICINE (KABSOM)

Kabale,

12th January 2022

To

The Chairperson,

Research Ethics Committee (REC)

Mbarara University of Science and Technology (MUST)

Dear Sir,

RE: RECOMMENDATION OF Mr. DENESI NIWARINDA'S MPH DISSERTATION PROPOSAL FOR RESEARCH

ETHICS REVIEW

This is to recommend the Master of Public Health (MPH) proposal of Mr. Denesi Niwarinda for Research Ethics Review by your Research Ethics Committee (REC).

Mr. Niwarinda is a *bona fide* second year MPH student in the Department of Community Health at Kabale University (Reg. No. 17/A/MPH/084/W). He has fulfilled all the internal requirements to proceed with his dissertation. He is a very keen student in all matters. He proposes to study:

"FACTORS AFFECTING MALE PARTNER SUPPORT DURING PREGNANCY AND CHILDBIRTH IN SELECTED HEALTH FACILITIES IN KABALE DISRICT"

I confirm that this proposal has been reviewed by the relevant authorities of the Department of Community Health and Kabale School of Medicine and approved for submission to your REC. The Department promises to offer him all the administrative, technical and mentorship support that he will need for this research, upon your approval of the study. Looking forward to favourable response from you,

Yours Sincerely,

Dr. Everd BIKAITWOHA MANIPLE, PhD (RCSI), MPH (MAK), MBChB (MAK)

Professor of Public Health Ag. Head, Department of Community Health

APPENDIX IV:

REC APPROVAL LETTER.

MBARARA UNIVERSITY OF SCIENCE AND TECHNOLOGY
RESEARCH ETHICS COMMITTEE
E-mail: sec.rec@must.ac.ug

Mbarara University of Science & Technology
P. O. Box 1410, Mbarara
RESEARCH ETHICS COMMITTEE
05 APR 2023
APPROVED
VALID UNTIL DATE SHOWN ABOVE

05/04/2022

To: Niwarinda Denesi

Kabale University
0784269235

Type: Initial Review

Re: MUST-2022-353: FACTORS AFFECTING MALE PARTNER SUPPORT AND CARE DURING PREGNANCY AND CHILD BIRTH IN SELECTED HEALTH FACILITIES IN KABALE DISTRICT, ,

I am pleased to inform you that at the **140th** convened meeting on **05/04/2022**, the MUST Research Ethics Committee, committee meeting, etc voted to approve the above referenced application.
Approval of the research is for the period of **05/04/2022** to **05/04/2023.**

As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the protocol or the consent form must be submitted to the REC for re-review and approval **prior** to the activation of the changes.
3. Reports of unanticipated problems involving risks to participants or any new information which could change the risk benefit: ratio must be submitted to the REC.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by participants and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Continuing review application must be submitted to the REC **eight weeks** prior to the expiration date of **05/04/2023** in order to continue the study beyond the approved period. Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. You are required to register the research protocol with the Uganda National Council for Science and Technology (UNCST) for final clearance to undertake the study in Uganda.

The following is the list of all documents approved in this application by MUST Research Ethics Committee:

No.	Document Title	Language	Version Number	Version Date
1	Updated consent form	Rukiga/Runyankole	PDF	2022-04-04
2	COVID-19 RISK PLAN	English	PDF	2022-03-18
3	Data collection tools	Rukiga	PDF	2022-03-18
4	Data collection tools	English	PDF	2022-03-18

Yours Sincerely

Bajunirwe Francis
For: MUST Research Ethics Committee

APPENDIX V

INTRODUCTORY LETTER

KABALE UNIVERSITY

P.O Box 317
Kabale - Uganda
Email: info@kab.ac.ug
admissions@kab.ac.ug

Tel: 256-392-848355/04864-26463
Mob: 256-782860259
Fax: 256-4864-22803
Website: www.kab.ac.ug

DEPARTMENT OF COMMUNITY HEALTH

KABALE SCHOOL OF MEDICINE (KABSOM)

District Health Officer
Kabale District
P.O. Box 5 Kabale

Kabale, 7th April 2022

To
The Responsible Officer,

Dear Sir/Madam,

RE: INTRODUCTION OF Mr. DENESI NIWARINDA DOING RESEARCH

This is to introduce to you Mr. Denesi Niwarinda, a student of the Master of Public Health (MPH) at Kabale University, requesting to do research in your community.

Mr. Niwarinda is a *bona fide* second year MPH student in the Department of Community Health at Kabale University (Reg. No. 17/A/MPH/084/W). He has fulfilled all the requirements of Kabale University School of Medicine to proceed with his dissertation. His research has been approved by the Uganda National Council for Science and Technology, represented by the Research Ethics Committee of Mbarara University of Science and Technology. It is entitled:

"FACTORS AFFECTING MALE PARTNER SUPPORT AND CARE DURING PREGNANCY AND CHILDBIRTH IN SELECTED HEALTH FACILITIES IN KABALE DISRICT"

Any assistance given to him in this regard will be very well appreciated.

Yours Sincerely,

Dr. Everd BIKAITWOHA MANIPLE, PhD (RCSI), MPH (MAK), MBChB (MAK), FAIPH
Professor of Public Health
Ag. Head, Department of Community Health
Tel: +256 772 592506 e-mail: ebmaniple@kab.ac.ug

APPENDIX: VI

ANTI-PLAGIALSISM REPORT

Turnitin *Originality Report*

- Processed on: 18-May-2023 14:43 EAT
- ID: 2096180002
- Word Count: 10598
- Submitted: 1

FACTORS ASSOCIATED WITH MALE PARTNER SUPPORT ... *By Niwarinda Denesi*

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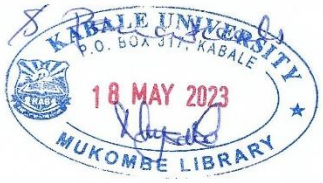


3% match (Internet from 03-Nov-2021)

https://www.researchgate.net/publication/343104620_Perception_of_pregnant_women_on_barriers_to_male_involvement_in_antenatal_care_in_Sekondi_Ghana

2% match ()

Matseke, Motlagabo G., Ruiter, Robert A. C. et al. "A Qualitative Exploration of the Meaning and Understanding of Male Partner Involvement in Pregnancy-Related Care Among Men in Rural South Africa", 'IUScholarWorks', 2017

2% match (Internet from 22-Dec-2022)

https://cris.maastrichtuniversity.nl/ws/portalfiles/portal/62118523/c6892.pdf

1% match ()

Paul, Pooja Lilly. "Gatekeepers or Equal Partners?: An Examination of Male Partner Attendance in Antenatal Care", 'Boston College University Libraries', 2021

1% match ()

Ampim, Gloria Abena. "Transforming gender relations? : Men's involvement in care for their partners and households at the time of pregnancy in rural and urban Ghana – a qualitative study", The University of Bergen, 2022

1% match ()

Daniele, M. A. S.. "Male partner participation in maternity care and social support for childbearing women: a discussion paper", 'The Royal Society', 2021

1% match (Yvonne Annoon, Thomas Hormenu, Bright Opoku Ahinkorah, Abdul-Aziz Seidu, Edward Kwabena Ameyaw, Francis Sambah. "Perception of pregnant women on barriers to male involvement in antenatal care in Sekondi, Ghana", Heliyon, 2020)

Yvonne Annoon, Thomas Hormenu, Bright Opoku Ahinkorah, Abdul-Aziz Seidu, Edward Kwabena Ameyaw, Francis Sambah. "Perception of pregnant women on barriers to male involvement in antenatal care in Sekondi, Ghana", Heliyon, 2020

1% match (student papers from 03-Nov-2021)

Submitted to Durban University of Technology on 2021-11-03

1% match ()

Secka, Ebba. "Men's involvement in care and support during pregnancy and childbirth", 2010

1% match (Internet from 05-Dec-2020)

https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-7371-3

1% match (student papers from 17-Aug-2022)

Submitted to The University of Dodoma on 2022-08-17

1% match (Internet from 11-Dec-2020)

https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0721-x

1% match (Internet from 18-Sep-2020)

https://www.dovepress.com/front_end/factors-influencing-male-participation-in-reproductive-health-a-qualit-peer-reviewed-fulltext-article-JMDH

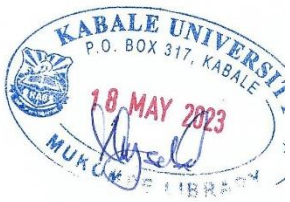
1% match (Internet from 11-Apr-2021)

http://ugspace.ug.edu.gh

1% match (Internet from 01-Nov-2022)

https://annalsofglobalhealth.org/article/10.5334/aogh.3003/

1% match (Internet from 22-Sep-2022)



https://www.globalscientificjournal.com/researchpaper/Male_partner_Involvement_in_Maternal_Health_An_Assessment_of_Knowledge_and_Practices_among_Men_in_Kuria_East_Sub_County_Kenya.pdf

1% match (student papers from 30-Jan-2020)

Submitted to University of Ibadan on 2020-01-30

1% match (Internet from 24-Dec-2022)

https://1library.net/document/zp2lwx0y-determinants-male-partner-involvement-antenatal-wakiso-district-uganda.html

1% match (student papers from 07-Dec-2020)

Submitted to Kenyatta University on 2020-12-07

1% match (Internet from 17-Nov-2022)

http://udsspace.uds.edu.gh

1% match (student papers from 07-May-2023)

Submitted to Mount Kenya University on 2023-05-07