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Original Research Article

Factors affecting male involvement in the uptake of maternal and child health services in Ndorwa County West, Kabale district

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ABSTRACT

Background: Maternal and Child Health care involves reproductive goals of; preventing unwanted pregnancies, decreasing high risk pregnancies, reducing morbidity and mortality and increasing accessibility to family planning services
Methods: It was cross-sectional study employing both qualitative and quantitative approaches. Information was captured from 288 men and women aged 18-45 involved in maternal and child health services.
Results: Data was analysed using SPSS version 21 to generate both descriptive and regression statistics. The study found out prevalence of male involvement in MCH services low at only 35.8%. Factors such as; level of education [AOR=2.331; (95% CI: 1.011–5.376); p=0.047], marital status [AOR=1.999; (95% CI: 1.026–3.893); p=0.042], cultural beliefs [AOR=0.561; (95% CI: 0.316–0.998); p=0.049], distance to the facility [AOR=0.416; (95% CI: 0.205–0.841); p=0.015] and rudeness of the health workers [AOR=1.942; (95% CI: 0.231–0.955); p=0.037] were significantly associated with low male involvement in MCH services. Shortage of financial resources, poor communication, and harassment by health workers were some of the challenges faced by men who accompanied their spouses for MCH services.
Conclusions: The study confirmed the prevalence of male involvement in MCH services low due to various factors such as cultural beliefs, shortage of finance and poor perceptions.

Keywords: Male Involvement, Uptake, Maternal, Child Health

INTRODUCTION

Globally, more than half a million women lose their lives from pregnancy-related complications worldwide every year, 99% of which occur in the less developed world like Africa.[1] In Sub-Saharan Africa alone, 1out of 13 women dies of pregnancy-related causes compared with one in 4,085 women in industrialized countries. In addition, many more women suffer short-term injuries, infections, and disabilities during pregnancy or child birth each year.[2] The tendency of taking Maternal and Child Health care as a woman's issue has contributed to a narrow focus of targeting mostly women, particularly mothers in intervention efforts.[3] Uganda is far much below the other East African Countries in reducing infant mortality.[4] Uganda Demographic and Health Survey (UDHS) report of 2015 indicate that the number of mothers dying while giving birth in the country was 438 deaths per 100,000 live births, while infant mortality stood at 54 deaths per 1000 live births.[5] According to Ministry of Health, the occurrence of maternal, neonatal, peri-natal and child deaths in the country, is a major concern for the government and all stakeholders.[6] Congruently, male involvement in MCH among other factors can contribute to the reduction of maternal and infant mortality.[7]

Acquiring information enables men to make appropriate and effective health care decisions for their partners and children.[8,9] The low participation of men in MCH related programs is determined by varying and sometimes similar factors).[9] Nevertheless, some factors cannot be generalized since regions vary in turns of economy, infrastructure, literacy levels and culture. In Ndorwa west, statistics indicate that only 17% of the men are involved in. The study was carried out to determine factors affecting male involvement in the uptake of maternal and child health services in Ndorwa west Health Sub district.

METHODS

Study setting

The study was conducted from Ndorwa west health sub district in Kabale district, South Western Uganda. Ndorwa west health sub district is one of the three counties that make up Kabale district and has a largest population of 95,321 people out of 230,609 total population of Kabale district.

Study design

A descriptive cross sectional design applying qualitative and quantitative approaches was used to generate and analyse responses from men and women (aged 18 – 45 participating in maternal and child health services like ANC and PNC services) and other key informants.

Sampling technique

A multi-stage procedure involving both simple random and purposive sampling techniques was adopted in the selection of respondents. The first stage involved a purposive selection of two (2) health centres 4s' and two (2) health centres 3s' across Ndorwa west. The second stage involved a random selection of respondents coming for ANC and PNC services at the facility. The researcher then randomly selected seventy two (72) respondents (38 men and 34 women) from each of the four selected health facilities to make a total of 288 respondents. The third stage involved a purposive selection of key informants who provided supplementary information that would not be provided by respondents.

Ethical considerations

Ethical approval for the study was obtained from the Research and Ethics Committee of TASO Uganda on reference number TASO-2021-42. Additional approval was obtained from authorities of Ndorwa West HSD before conducting the study. A written informed consent was obtained from each participant after giving a description and purpose of the study. Confidentiality was seriously observed throughout the study process. This was achieved by hiding identities of the respondents, full consent was obtained from participants prior to the study

Data collection

A pre-tested, structured questionnaire was designed and used to collect the data. The tool had both closed ended and open ended questions designed and used to generate quantifiable information from the respondents.

Iinterviews were also conducted to enable the researcher get information from the key informants using interview guide. The study was conducted for a period of 10 months; October 2019 to June 2020.

Data management and analysis

Data collected from the field was edited for any inconsistencies and appropriately coded, and entered using SPSS software Version 21. Univariate analysis was performed to generate frequency and percentages while odds ratios were performed to draw the possible associations between the men's involvement and associated factors. Bivariate and multivariate logistic regression analysis was used in determining the factors associated with men's involvement in MCH services. The significance level was set at a p-value of < 0.05. Data from interviews and FDGs was analyzed through thematic content analysis.

RESULTS

Regarding whether men attended MCH services with spouse, more than a half (64.2%) of the respondents said no and only 35.8% said yes. On the number of times women attended MCH services with spouse, 22.2% of the respondents reported that they always attended with their spouses, 34.4% sometimes while 43.4% said they rarely. 35.3% of respondents indicated that men accompanied their spouses for deliveries, 28.4% antenatal care, 18.6% postnatal care, 11.4% birth preparedness and 6.2% immunization.

20.9% of the respondents reported that they never attended MCH services with spouses due to lack of finance, 20.5% said men are always busy with other activities, 17.5% mentioned long distance to the facility, 14.4% alleged the program was for only women, 13.7% lack of interest, 7% shyness and 5.9% talked of unfriendly health workers. In an interview with one of the male respondents, he had this to say;

"……i have always failed to involve in maternal and child health services not because I don't want to but because am always busy with different activities to generate enough income to support my family. Besides that arrangement is for women, I don't normally find any reason to involve in it".

A big number (40.9%) of respondents reported that husbands offered support in form of financial, 22.2% accompaniment, 18.6% sharing health information while 18.2% mentioned psychological support.

Table 1: Demographic characteristics (n=288).

Variable	Values	Frequency	%
Gender	Male	155	53.8
	Female	133	46.2
Marital status	Single	52	18
	Married	167	57.9
	Separated/ divorced	69	23.9
Tribe	Munyankole	67	23.3
	Mukiga	121	42
	Rwandese	15	5.2
	Others	85	29.2
Religion	Catholic	129	44.8
	Protestant	142	49.3
	Muslim	10	3.4
	No religion	7	2.4
	Min.	**Max.**	**Mean±SD**
Age (in years)	18	45	33.08±11.671
Level of education (in years)	0	16	10.21±4.341
Size of the household	3	12	6.89±2.235

According to the table above, Age bracket of men increased the log of the probability of male involvement in MCH services by 1.960. Older age was more associated with male involvement in MCH services compared to young age. This is because the more the age, the more the marital experience gained and hence increasing likelihood of involving in marital issues compared to young age. In an interview with one of the clinical officers, she revealed;

"……..it is obvious that male involvement in MCH services goes with age, the more the years, the more the marital experience and this places older people at a high percentage of involving in MCH services than the young inexperienced people".

Level of education increased the log of probability of male involvement in MCH services by 2.051. Educated men were 2.051 times more likely to involvement in MCH services compared to un-educated men. This is because education boosts men's knowledge and capacity to make informed decisions regarding marital affairs. Therefore it was not surprise for education to emerge as a significant predictor to male's involvement in MCH services. In an interview with one of the MCH coordinators, he revealed;

"…….education level is the biggest obstacle to MCH service uptake we currently have in this area. With a big percentage of people who have never attended/completed education, implementation of MCH programs has remained a big challenging".

Marital status (none married) decreased the log of probability of male involvement in MCH services by 3.666. Men that were not married were 3.666 times less like to involve in MCH services. This because being married increases marital experience and hence the probability of a husband escorting the wife for MCH services to avoid the likely outcomes.

Household size increased the log of the probability of male involvement in MCH services by 2.954. Men with much bigger households were 2.954 times more likely to involve in MCH services than those with smaller households. This is because knowledge on MCH services accumulates with the number of children hence giving men with more children an advantage of knowledge and experience in MCH.

Income status presented a significant association with male involvement in MCH services. Men with high income presented 1.781 chances of involving in MCH services compared to those with low income. Income gives men an opportunity to meet all the necessary costs during maternity hence leaving no doubt of those with much more money involving in MCH services than the poor. In an interview with one of the male respondents, he had this to say;

"……..it would be my wish to involve in MCH services, but my greatest obstacle is low income. Attending MCH services comes with a cost in terms of transport and other issues yet my monthly earnings cannot even support my family throughout the whole month".

Cultural beliefs decreased the log of the probability of a male involving in MCH services by 2.351 and this was significant at p=0.003. This implied that men who came from households with deep rooted believes were 2.3times likely to involve in MCH services compared to men from households with normal beliefs. In an interview with one of the MCH coordinators, he revealed;

"…….culture is one of the major contributors to low involvement in MCH services in this area. For example a big number of men have a belief that MCH services is a woman's thing and this perhaps why there are a few men who escort their wives for MCH services".

Like beliefs, attitude and perceptions decreased the log of the probability of male involvement in MCH services by 1.109. The more men the negatively perceived MCH services, reduced the chances of involving in MCH services by 1.1 and this was statistically significant at (p=0.015).

Table 2: Prevalence of male involvement in MCH services in Ndorwa west HSD (n=288).

Variable	Category	Frequency	Percentage
Whether men attended MCH services with spouse	Yes	103	35.8
	No	185	64.2
Number of times women attended MCH services with spouse	Always	64	22.2
	Sometimes	99	34.4
	Rarely	125	43.4
MCH services for which men accompanied their spouses (multiple responses generated) (n=306)	Antenatal care	87	28.4
	Birth preparedness	35	11.4
	Delivery	108	35.3
	Postnatal care	57	18.6
	Immunisation	19	6.2
Reasons for not attending MCH services with spouses (multiple responses generated) (n=424)	Facility too far	74	17.5
	Busy with other activities	87	20.5
	Health workers not friendly	25	5.9
	No Interest	58	13.7
	Programme is for women	61	14.4
	Shyness	30	7
	Lack of finances	89	20.9
Form of assistance provided by husbands during MCH services (multiple responses generated) (n=472)	Sharing health information	88	18.6
	Accompaniment	105	22.2
	Psychological support	86	18.2
	Financial support	193	40.9

Table 3: Parameter estimates for associated factors affecting male involvement in the uptake of MCH services.

Variable	Value	AOR (95% CI)	P value
Age	In years	1.635 (0.265 – 2.518)	0.337
Level of education	In years	2.331 (1.011 – 5.376)	0.047
Marital status	Never married	1.999 (1.026 – 3.893)	0.042
	Married	1	
Religion	Christian	0.749 (0.345 - 1.626)	0.465
	Muslim	1	
Employment status	Employed	1.008 (0.649 - 1.567)	0.971
	Un-employed	1	
Household size	Members at HH	2.954 (0.593 - 4.536)	0.028
Tribe	Mukiga	0.918 (0.553 - 1.526)	0.743
	Others	1	
Number of children	Number	0.864 (0.532 - 1.402)	0.554
Income status	High	1.781 (0.475 - 2.285)	0.031
	Low	1	
Place of residence	Urban	0.315 (0.486-3.563)	0.590
	Village	1	
Knowledge on MCH	Yes	0.761 (0.471 - 1.229)	0.264
	No	1	
Cultural beliefs	Yes	0.561 (0.316 – 0.998)	0.049
	No	1	
Attitude and perceptions	Yes	1.109 (0.672 - 2.830)	0.015
	No	1	
Un-flexible clinic schedules	Yes	0.315 (0.486 - 3.563)	0.590
	No	1	
Distance to the facility	In kilometers	0.416 (0.205 – 0.841)	0.015
Rudeness of health workers	Yes	1.942 (1.036 – 3.640)	0.038
	No	1	
Waiting time at the facility	Yes	0.469 (0.231 – 0.955)	0.037
	No	1	

Table 4: Challenges faced by men who accompany their wives for MCH services (multiple responses were generated).

Challenges	Frequency	Percentage
Dominance by female staff in MCH services	45	12.4
Poor couple communication	57	15.7
Shortage in financial resources	80	21.9
Harassment by health workers	67	18.4
Poor attitude of health workers	30	8.2
Long waiting hours	46	12.6
Restricted entry into the maternity ward	39	10.7
Total	364	100.0

Distance to the facility was another significant predictor in males' involvement in MCH services and was statistically significant at (p=0.005). This implied that a unit increment in distance from residence to the health facility by a kilometer reduced the chances of male involvement in MCH by 1.8. In an interview with one of the male respondents, he had this to say;

"……..i wouldn't have any issue escorting my wife for maternal and child health services but the distance we have to travel to the nearest health Centre demoralizes me. Can you image walking 7km to the nearest health facility".

Rudeness of the health workers decreased the log of the probability of male involvement in MCH services by 2.7 and this was significant at p=0.002. Men who had rude encounters with heath workers in the previous visit(s) were 2.7 times less likely not to show up for the next MCH service visits.

The most common challenge cited in the table above was shortage in financial resources reported by 21.9% of total respondents, 18.4% quoted harassment by health workers, 15.7% poor couple communication, 12.6% long waiting hours at the facility, 12.4% dominance by female staff in MCH services, 10.7% restricted entry into the maternity ward and 8.2% poor attitude of health workers.

DISCUSSION

The study revealed a low prevalence of male involvement in MCH services. This low prevalence was more in young men than the older ones. Only 35.8% of men were reported to involve in MCH services though most of them didn't accompany spouses for the services occasionally These study findings are in line with findings by in Northern Uganda where 48% of men accompanied their partners during delivery but 65% did the same for antenatal care.[3] Educated men were 2.051 times more likely to involvement in MCH services compared to un-educated ones. This is because education boosts men's knowledge and capacity to make informed decisions regarding marital affairs. This study finding concurs with who reported that men who had 8 or more years of education were 2 times more likely to get involved in maternal health care than those with less education.[10]

Men from households with deep rooted believes were less involved in MCH services compared to those from households with normal beliefs. This finding concurs with who revealed that most communities around the world still rely on their culture to dictate their health choices, especially on pregnancy and child birth.[11]

According to the study, poor attitude of health workers and fear of being harassed by health workers were some of the reasons cited to be contributing to low male involvement in maternal health care services. The study finding is consistent with a study conducted by reported that harsh and critical language directed at Ugandan women from skilled health professionals was a barrier to male participation.[9] Poor communication between men and their female partners was associated with poor male involvement. It was reported that most men misinterpreted campaign messages promoting male involvement to mean that decisions should solely be left to men. This finding is comparable to, in their research highlighted an example of a breakdown in communication among couples where they reported that some men did not want to discuss ANC attendance with pregnant women because they considered them to nag a lot.[6]

Long waiting hours at the facility was predictive of decreased male involvement in accompanying the wife for health care services. Frequently women together with their husbands have to wait for a long time before receiving ANC services because of burdensome administrative procedures which result in poor patient/ client through-put in health facilities. The finding of this study is in agreement with the findings from several studies that have reported long waiting time at the health facility as being one of the reasons for low male involvement in accompanying their partners for maternal health services.[12] It is possible that if waiting time at the health facility were reduced it will result in increased male accompanying the wife and child for postnatal care. This is because many men have long working hours and long waiting time makes it difficult to find off time to attend maternal health services.

Dominance by female staff in ANC programs acts as a challenge to male involvement in MCH services; antenatal and maternity are always regarded by the

general public to be a domain of female health workers since traditionally the nursing profession has been dominated by women. Majority of men therefore find it uncomfortable seeking services with their partners, unless a male health care worker is also present. This is comparable to findings from a study in ten sub-Saharan countries, more than half of study participants agreed that they no longer attend antenatal clinic since most of the times they went they would encounter female nurses at the clinic.[1]

Respondents further reported restricted entry into maternity wards at health facilities as a factor why most men never involve in MCH services. According to this study, the fact that health workers don't allow men to enter into the maternity ward is responsible for some men not accompanying their partners for maternal health services. Some men indicated that even when men accompanied their partners to the facility, they generally waited from outside. Similar findings were reported in the study carried out in South Africa. In South Africa, some men indicated that even when men accompanied their partners to the clinic, they generally waited from outside.[3]

CONCLUSION

In conclusion, the study confirmed the prevalence of male involvement in MCH services in Ndorwa west, Kabale district as low. This was attributed to various significantly associated factors like; age, level of education, marital status, household size, income status, cultural beliefs, attitude and perceptions of health workers, distance to the facility and rudeness of the health workers, prohibitive cultural norms, and unfavourable health policies. Shortage in financial resources, poor communication, harassment by health workers, long waiting hours at the facility, restricted entry into the maternity ward and poor attitude of health workers were confirmed as the key challenges men come across when accompanying their spouses for MCH services.

Recommendations

There is the need for urgent interventions to scale up the involvement of men in MCH utilization.

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