

**ASSESSMENT OF THE FACTORS THAT HINDER MALE INVOLVEMENT IN
MATERNAL HEALTH IN KASANGATI TOWN COUNCIL:A CASE STUDY IN
KASANGATI HEALTH CENTRE IV, WAKISO DISTRICT**

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**UGANDA CHRISTIAN
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DECLARATION

I, Agunyo Peace Nepilu a student at Uganda Christian University pursuing a bachelor in social work and social administration declare that this research proposal has never been presented in any other university or institution of higher learning for any academic award.

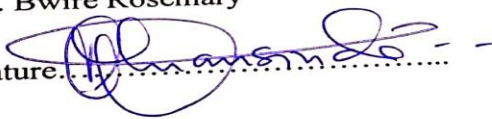
Signature.....

Date.....

APPROVAL

This is to certify that this proposal is submitted with my approval as a supervisor

MRS. Bwire Rosemary

Signature.....

Date.....09/05/2025.....

DEDICATION

This dissertation is dedicated to the Almighty God, my parents, Mr. and Mrs. Epilu Stephen, and my friends. To my supervisor, Mrs. Bwire Rosemary, in particular, who battled to teach, mentor, train, and counsel me throughout my research project, only to reveal my deeply responsible inner self.

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Table of Contents

DECLARATION.....	ii
APPROVAL.....	ii

DEDICATION	iii
ACKNOWLEDGEMENT	iv
ABSTRACT.....	viii
CHAPTER ONE	1
INTRODUCTION	1
1.0. BACKGROUND OF THE STUDY.....	1
1.1. PROBLEM STATEMENT.....	5
1.2. STUDY OBJECTIVES	6
1.2.1. General Objectives.....	6
1.2.2. Specific Objectives	6
1.3. RESEARCH QUESTIONS	6
1.4. SCOPE OF THE STUDY	7
1.4.1. Content scope of study.....	7
1.4.2. Geographical scope.....	7
1.4.3. Time scope	7
1.5. SIGNIFICANCE OF THE STUDY.....	7
1.6. OPERATIONAL DEFINITIONS.....	8
CHAPTER TWO	9
LITERATURE REVIEW	9
2.0. INTRODUCTION.....	9
2.1. SOCIO- CULTURAL NORMS AND MATERNAL HEALTH.....	10
2.2. LACK OF AWARENESS AND MATERNAL HEALTH.....	11
2.3. LEVEL OF EDUCATION AND MATERNAL HEALTH.....	12
CHAPTER THREE	15

METHODOLOGY	15
3.0. INTRODUCTION.	15
3.1. RESEARCH DESIGN.	15
3.2. AREA OF STUDY.	15
3.3. STUDY POPULATION.....	15
3.4. SAMPLE SIZE	15
3.5. SAMPLING TECHNIQUES	16
3.6. DATA COLLECTION METHODS	16
3.6.1. Interview method.	16
3.6.2. survey method.....	16
3.6.3. Observation method.	17
3.7. DATA PROCESSING AND ANALYSIS.	17
3.7.1. Data processing.	17
3.7.3. Data coding.	17
3.7.4. Data tabulation.	17
3.8. ETHICAL CONSIDERATION.....	
3.9. LIMITATIONS OF THE STUDY.....	18
CHAPTER FOUR.....	18
PRESENTATION AND INTERPRETATION OF FINDINGS	18
4.0 Introduction.....	Error! Bookmark not defined.
4.1 Response rate	19
4.2 Demographic Information of the respondents	19
4.2.1 Gender.....	19
4.3.3 Highest level of education	20

4.4 KEY STUDY FINDINGS.....	21
4.4.1 Socio- cultural norms and hindrance male involvement in maternal health in Wakiso district.....	21
4.4 .2 Lack of awareness hindrance of male involvement in maternal health in Wakiso district.	23
4.4.3 Level of education and hindrance of male involvement in maternal health in Wakiso district.....	24
CHAPTER FIVE	27
SUMMARY AND DISCUSSION OF RESULTS	27
5.0 Introduction.....	27
5.1.1 Socio- cultural norms and hindrance male involvement in maternal health in Wakiso district.....	27
5.1.2 Lack of awareness hindrance of male involvement in maternal health in Wakiso district.	27
5.1.3 The Level of education and hindrance of male involvement in maternal health in Wakiso district.....	28
5.2 DISCUSSION OF FINDINGS	28
5.2. 1 Socio- cultural norms and hindrance male involvement in maternal health in Wakiso district.....	28
5. 2.2 Lack of awareness hindrance of male involvement in maternal health in Wakiso district	29
5.2. 3 The Level of education and hindrance of male involvement in maternal health in Wakiso district.....	30
CHAPTER SIX.....	31
CONCLUSIONS AND RECOMMENDATIONS	31
6.0 Introduction.....	31

6.1 Conclusion	31
6.2 Recommendations.....	32
REFERENCES	32
APEDDICIES	35
APPENDIX I: CONSENT LETTER UGANDA CHRISTIAN UNVERSITY	35
APPENDIX II: INTERVIEW GUIDE.....	39

ABSTRACT

The Kasangati Town Council study looked into the barriers to male participation in maternal health. The following goals served as the study's guidelines: To determine whether sociocultural norms prevent men from participating in maternal health at Kasangati Health Center IV, Kasangatii Town Council; whether ignorance prevents men from participating in maternal health at Kasangati Health Center IV, Kasangatii Town Council; and whether educational attainment prevents men from participating in maternal health at Kasangati

Health Center IV, Kasangatii Town Council.

Both qualitative and quantitative methods were used in the study's modified descriptive research design.

According to the study, cultural beliefs in the community have a significant influence on how pregnant women feed their babies. This suggests that even though the men would want to provide their expectant mothers with a healthy, balanced diet, some foods are forbidden in their society, even though they are nutritious. The obstacles to male participation in maternal health at Kasangati Health Center IV would also be removed by raising knowledge of men's involvement in reproductive health, family planning initiatives, and reproductive health decision-making.

The study concluded that there was still a lack of knowledge regarding family planning programs, men's involvement in reproductive health, and men's role in reproductive health decision-making. Raising awareness is therefore necessary to remove the obstacles that prevent men from participating in maternal health in Kasangati Health Center IV and the entire Wakiso area.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

Promoting mother and family health requires male participation in reproductive health. Despite the fact that both men and women are responsible for participating in mother and child health (MCH) activities, males in Uganda do not actively participate in the majority of MCH services or other reproductive health initiatives. The study's background, problem statement, purpose, objectives, research questions, significance, restrictions and delimitations, assumptions, conceptual and theoretical frameworks, and operational definitions of terminology are all presented in this chapter.

1.1 . BACKGROUND OF THE STUDY.

Given that men and women are regarded as partners in sexuality and reproduction, reproductive health frequently suggests that both are active in the process. Men's actions and reproductive health also have a significant influence on women's reproductive health, the welfare of children, and society at large.

Despite their frequent ignorance about women's and their own reproductive health requirements, males play a vital role in enabling women around the world to access healthcare, particularly reproductive health care. Therefore, the significance of male involvement in sexual and reproductive health (SRH) has gained more acknowledgment in recent decades.

This was made evident when it became apparent that their partners' sexual and reproductive health requirements were being met by the AIDS epidemic debate (Salem, 2004).

In 1994, the International Conference on Population and Development (ICPD), which was attended by 180 nations, officially acknowledged the significance of men for women's reproductive health as well as the significance of men's reproductive health. Promoting men's

increased involvement and support of women's needs, rights, sexual and reproductive health, and choices is the main goal of male involvement. It focuses on the needs and behaviors of males with regard to sexual and reproductive health (MEDiCAM, 2004). The prevalence of contraception may rise and maternal rates may fall as a result of male involvement in maternal health care.

Male involvement can help lower the overall prevalence of HIV/AIDS, which is beneficial if males are involved as partners, service providers, policy makers, educators, and project managers in addition to being customers of reproductive health (MEDiCAM 2004). Therefore, the International Conference on Population and Development (ICPD) called for all nations to offer convenient, inexpensive, accessible, and acceptable reproductive health care to both men and women.

A research carried out in Ethiopia's Oromia regional state revealed that 89% of men participated in choosing their spouse's place of delivery(UNICEF2021). The degree to which women use maternal health services in patriarchal nations is influenced by social norms, morals, and a lack of enthusiasm for women's empowerment. Therefore, involving male partners in maternal health services in these areas may be a good way to reduce maternal morbidity and mortality. Planning a successful intervention strategy to increase men's involvement in the maternal health care system requires evaluating their present level of awareness and involvement.

Thus, the goal of the current study was to evaluate men's knowledge of obstetric risk signs, birth readiness, and complication readiness in North West Ethiopia.

However, despite the growing global awareness of the significance of male participation in reproductive health, several nations still lack extensive health services that can effectively outreach to males. Africa is a particularly difficult case.

In nations where male participation in sexual and reproductive health is impeded by culturally determined gender roles, male involvement in productive health is especially difficult (Watson et al., 2005).

This is particularly true in situations involving aggression against women, risky sexual behavior, alcohol use, and poor communication between couples and male domination.

Ghana, an African nation, has made relatively little progress in addressing the sociocultural issues that impact men's participation in sexual and reproductive health over the years. The Ghanaian government established a national population policy in 1969. The primary goal was to solve the issue of rapid population expansion in relation to the economy's sluggish growth rate (Benneh et al., 1989).

However, in Ghana, the involvement of men in family planning has received more attention and interest than mother and child health when it comes to reproductive choice making (Fayorsy C. 1989, Edger et al 1992, Ezeh A.C 1993, Ezel et al 1996). Accordingly, little is known about the role that males play during pregnancy in Ghana and other parts of Africa (Dudgron and Inhorn 2004, Sternberg and Hurley 2004, Becker and Robinson, 1998).

Men's engagement in maternal health stems from their many affects on nearly every aspect of life. The male-dominated "Patriarchy" practice has been mostly blamed for men's negative attitudes toward maternal health, particularly in Africa. African men's support and participation in maternal health care are vital for the wellbeing of both mothers and children, as they play a significant influence in family decisions.

In East Africa, there is a correlation between better mother and child health outcomes and male participation in maternal health and other sexual and reproductive health programs. In many East African nations with high rates of maternity and neonatal mortality, women do not make the majority of the decisions.

Men have historically been the leaders of households and have a significant say in decisions about how to use health care for women and children. Women and children have benefited greatly from their involvement as partners in prenatal care, birth, and child services. According to reports, males who are involved in pregnancy and receive nutrition and counseling can lower the number of low-birth-weight babies delivered as well as the child death rate (UNICEF 2018).

Despite its benefits, the percentage of males who participate in antenatal care is relatively low, ranging from 34.6% to 63%, in low- and middle-income nations like Tanzania, where mothers are the primary caregivers (MOH 2017). Various tactics have been used to increase male participation, such as providing first-track services to expectant mothers who go with their partners, as demonstrated in Southern Tanzania, and in other locations, extending services on the weekends or beyond work hours to meet men's hectic schedules. While some of the interventions produced favorable results, others had the reverse effect.

In Tanzania, 34% of pregnant women attend postnatal care (PNC) within 48 hours after giving birth, 64% use SBAs during childbirth, and 96% of pregnant women attend at least one antenatal care visit, while just 5% attend the recommended four or more antenatal care visits.

The World Health Organization (WHO) has set national goals that by 2020, 80% of women will give birth with SBAs and 90% of women will receive the necessary four or more prenatal care visits.

Over the past few decades, the Ugandan government has created a number of measures aimed at encouraging male participation directly as part of a larger plan for women's growth. The 2007 Uganda Gender Policy, the National Policy of Elimination of Gender Based Violence, and the National Infant and Young Child Feeding program have all emphasized the significance of the power dynamics between men and women as well as the need to increase men's active participation through community involvement and education campaigns.

The government's recent initiative to train and equip men to educate their peers about family planning, reproductive, and maternal health services at the grassroots level was the Male Action Group (MAG) program.

The Uganda Bureau of Statistics (UBOS 2023) reports that the country has one of the highest rates of maternal and infant mortality worldwide. The current rates of maternal mortality

(MMR) are 343/100000 live births and infant mortality (IMR) are 45/1000 live births. One-fourth of women are reluctant to visit medical facilities by themselves, and nearly half of them lack the funds to pay for treatment for consequences. Outside of medical institutions, more than half of all women give birth. The health system's response to delays in seeking care, getting to hospitals, and receiving the right care has acknowledged the importance of male involvement.

Male involvement levels are still quite low, even with the apparent policy emphasis. In 2016, a cross-sectional survey of 384 males in the Wakiso region revealed that just 6% of men went to prenatal checkups with their spouses. Studies have criticized the uneven coverage of male involvement programs nationwide and similar observations have been made in other parts of Uganda. The viewpoints and experiences of important stakeholders, including government representatives, medical professionals, and members of civil society, have not yet been evaluated in the literature. The opinions of these stakeholders, who are important policy makers, are essential to comprehending the difficulties and procedures of implementation.

In order to close this gap, this study examines the opinions and experiences of important Ugandan stakeholders with relation to the agenda for male inclusion.

1.2 PROBLEM STATEMENT

One of the districts impacted by this high rate of maternal mortality is Wakiso district, which is a general rural context. Improving the situation requires recognizing and resolving the major concerns influencing maternal health. The lack of male participation in maternal health is one such problem. Women's maternal health is positively impacted by male involvement in maternal health. For instance, certain aspects of prenatal, delivery, and postnatal care—particularly those with nutritional, psychological, and medical goals—have been demonstrated to enhance birth outcomes and lower maternal complications, especially in settings with limited resources (Carroli et al., 2001; Lumbiganon, 1999). But men must be involved in order to handle these and other aspects of maternal care. However, anecdotal information indicates that in the Wakiso district's Kasangati town council, male involvement in maternal health is typically minimal. It appears that the health system's capacity to create and execute plans for boosting male involvement in maternal health may be hampered by a general lack

of understanding regarding the topic.

Increased male involvement in maternal health will result in better maternal health outcomes if the factors influencing male involvement are recognized and addressed.

Through this study, the Kasangati town council will be able to better understand the factors that influence male involvement in maternal health. Additionally, it will make it easier to create plans and initiatives that will enhance maternal health by enlisting men in productive ways.

1.3. STUDY OBJECTIVES

1.3.1. General Objectives

A study to investigate the factors that hinders male involvement in maternal health in Kasangati town council.

1.3.2. Specific Objectives

- i) To assess the role of socio- cultural norms hinder male involvement in maternal health in in kasangati health centre IV, Kasangatii Town council
- ii) To establish the effect of lack of awareness and knowledge on male involvement in maternal health in kasangati health centre IV, Kasangatii Town council
- iii) To find out the effect of level of education on male involvement in maternal health in kasangati health centre IV, Kasangatii Town council

1.4 . RESEARCH QUESTIONS

- i) what is the effect of socio cultural norm on male involvement in maternal health in in kasangati health centre IV, Kasangatii Town council ?

ii) How has knowledge and awareness affected male involvement in maternal health in in kasangati health centre IV, Kasangatii Town council?

iii) what is the effect of the males level of education on their involvement in maternal health in in kasangati health centre IV, Kasangatii Town council ?

1.5 . SCOPE OF THE STUDY

1.5.1. Content scope of study.

The study was focused on the factors that hinder male involvement in maternal health in wakiso district. Its objectives are; to find out whether socio cultural norms hinders male involvement in maternal health, to find out whether lack of awareness hinders male involvement in maternal health, to find out whether lack of education hinders male involvement in maternal health in Wakiso district.

And the research questions were; Does socio cultural norms hinders male involvement in maternal health, does lack of awareness hinders male involvement in maternal health, does lack of education hinders male involvement in maternal health in Wakiso district.

1.5.2. Geographical scope.

The study was conducted at Maternal Child Health clinic in Kasangati health centre IV, kasangati town council, Wakiso district.

1.5.3. Time scope

The study considered data for the period 2017 — 2021 for during this period many cases of unsafe maternal care were reported in Wakiso district

1.6. SIGNIFICANCE OF THE STUDY.

The study will help the social worker to acquire more knowledge and skills in writing and conducting data in social related issues in the society with an aim of achieving an academic requirement in a diploma in social work.

The study will provide literature for other researchers to examine the factor that hinders male involvement in maternal health in wakiso district.

The study will help the policy makers to design measures and strategies on how to control low levels of male involvement in maternal health which will be a go ahead in boosting maternal health in Uganda.

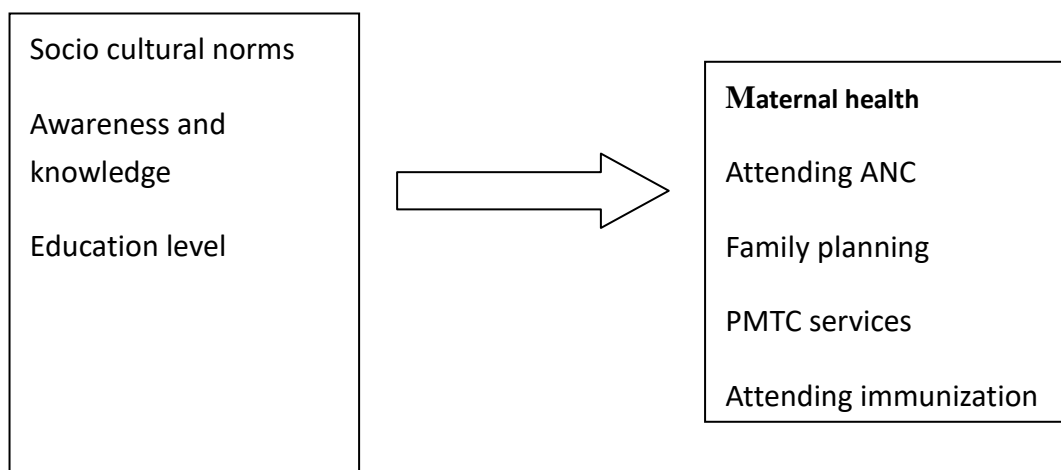
The study will be of use to students in investigating on the factors hindering male involvement in maternal health in their different fields of study.

1.7 Conceptual framework

The conceptual framework in figure 1 below depicts the relationship between the study variables.

Independent variable

Dependent variable



source; Adopted from WHO (2019) and modified by the researcher

The conceptual framework in figure 1 above presents the relationship between the independent variables (ie sociocultural norms, awareness and knowledge and education level) and the independent variable maternal health. its assumed that the independent variables collectively or individual can affect male involvement in maternal health at kasangati .

1.8 OPERATIONAL DEFINITIONS.

Male involvement.: This addresses mens sexual and reproductive health needs and behaviour. It includes encouraging men to become more involved and supportive of womens needs, rights and sexual reproductive health.

Pregnancy; This is a state of carrying a growing embryo or foetus in the uterus, the interval of time beginning when an egg and sperm unite and ending when and a baby is born.

Post-natal care. These are activities that occur relating to supporting the health and well-being of the mother and the new baby.

Barriers: These are things that will stop men from taking part in the affairs or health of his partner and supporting his partner during child birth, after she gave birth and continue take care of her and the baby.

Awareness: The information understanding and skills that were gained through education or experience that supports or defers the involvement of male in maternal, delivery and postnatal periods.

Socio cultural norm: These are rules that a group or society uses to determine what is appropriate and in appropriate in behaviour, expression and values.

CHAPTER TWO

LITERATURE REVIEW

2.0. INTRODUCTION.

A literature is a survey of scholarly sources on a specific topic. It provides an overview of

current knowledge, allowing you to identify relevant theories, methods and gaps in the existing research. This chapter involves the review of the related literature of the study.

2.1. SOCIO- CULTURAL NORMS AND MATERNAL HEALTH.

Geografia (2014) investigates the traditional and sociocultural practices related to maternal health in Nigeria's Sokoto state. In the zone, these customs are important to the lives of the female flocks. Nigeria has more than 300 distinct ethnic or linguistic groups and dialects, according to previous studies. Information and data for this study came from a variety of sources, including field observations, recent research in international journals, other scholars, government publications, United Nations reports, USAID resources, and international materials from Pathfinder.

According to the findings, a high maternal mortality rate in the state is thought to be caused by tradition-inspired practices and norms like female genital mutilation, forced marriage, early marriage, unattended labor and delivery, low educational attainment, hot bathing (Wankan Jego) during childbirth, using herbs, child spacing, and traditional gender discrimination. These practices and norms also have a significant impact on maternal health. Even while these practices are more common among women with lower levels of education, their overall impact is still significant despite widespread modernity, therefore if maternal mortality is to be decreased, they must be addressed more directly. Therefore, the study suggests that rather than funding the construction of more contemporary medical facilities that are wildly underutilized, equal efforts should be made to address the state's women's traditional attitudes and behaviors.

According to Okutu (2011), women in Uganda who are younger (less than 20 years old) and middle-aged (between 20 and 34 years old) are more likely than mothers who are older (34 years old) to seek pregnancy-related care services from trained attendants.

Studies conducted in Nigeria have shown that health-seeking behavior rises with age and falls with age (Nwosu et al., 2012, for instance). The authors relate this condition to older women' accumulated experience and the low number of pregnancies at this age. Furthermore, it was shown that older Ethiopian women preferred to give birth at home with the help of traditional

birth attendants but were reluctant to seek medical attention (UNFP 2008; Regassa 2011). However, Asimwe (2010) discovered that in Western Uganda, young mothers' use of maternal health care is determined by affordability rather than age, which runs counter to Okutus (2011)'s findings. Heidi et al. (2006) found no discernible difference between young and old mothers in Uganda regarding the use of antenatal and delivery health care services.

2.2. LACK OF AWARENESS AND MATERNAL HEALTH.

Many studies have demonstrated that men serve as gatekeepers to women's health seeking behaviors and use of health services in a variety of contexts, despite the low levels of health knowledge (Carter 2002, Matsuyama 2002, Ghararo 2000, UNFPA 2000, Adewuy 1999, Thaddeus and Maine 1994). Thus, males participate in reproductive decision-making, and in communities where power is distributed equally, men may even have significant influence over the sexual orientation of their partners (Green et al., 2012; Schiller et al., 2011). In most societies, women are less able to acquire resources, skills, and education than men (Sivard 1995).

The sexual and reproductive health of women is affected by the fact that males are more likely than women to control sexual contact and decision-making in this setting (du-Guerny and Sjoberg 1993; Green et al 2012).

Studies showing that men have an impact on decisions about reproductive health are becoming more numerous (Gage 1998, Ezeh 1992).

According to these research, family planning initiatives that focus on women are more likely to be successful if they also promote male participation (Biddlecoman and Fapohunfa 1998a; 1998b). Women may use reproductive health services less frequently if men are excluded from programs that focus on reproductive health in societies where men make the majority of reproductive decisions (Greene et al., 1995; 2012).

Men's involvement in reproductive health is likely to promote their partners' usage of contraception and expand the range of techniques available to a couple. Involving males in reproductive health is also justified by their duty to safeguard their offspring. Additionally, males must accompany women during their pregnancies and deliveries in order to provide couples the best chance of having a healthy kid. Decisions made by men have a big influence on women's health. Men can play a significant role in making sure their pregnant partner gets the care they need both during and after their pregnancy.

Certain aspects of prenatal care, especially those with nutritional, psychological, and medical goals, have been demonstrated to enhance delivery outcomes and lower mother difficulties, especially in environments with limited resources (Carroli et al., 2001; Lumbriganon, 1999). According to Bloom et al. (2001), Beegle et al. (2001), and Piet-Pelon et al. (1999), the most crucial factors in guaranteeing a successful pregnancy and birth may not be within the pregnant woman's control, but rather the management of the family, typically the husband. According to Gross, Schellenberg, Kesey, Pfeiffer, and Obrist (2011), the antenatal time offers great chances to provide vaccinations, preventative medication, infectious illness diagnosis and treatment, and health education programs to expectant mothers.

2.3. LEVEL OF EDUCATION AND MATERNAL HEALTH.

Education for both men and women has been linked to an increase in the use of maternal care services, according to several researches (Celik and Hotchkiss 2000, Gubhaju 2000). Men and women with higher levels of education are more likely than those without to seek prenatal care, to do so early and often, and to use medical facilities and qualified practitioners. The Ethiopia DHS 2011 results, which show that between 70 and 72 percent of newborns to women with some secondary education were attended by a healthy facility, compared to only 5 percent of births to moms with no education (Central Statistical Agency and ICF Macro 2011), further support this.

Additionally, it has been discovered that education has a good correlation with various facets of maternal care. For instance, a study conducted in Nepal revealed that men and women who had completed more than primary school were more likely than those who had not to seek out

or use antenatal care. (Gubhaju, 2000).

Men and women with six or more years of education were found to be more likely than those without any education to use or seek antenatal care while in Turkey. (Hotckiss and Celik, 2000).

A statistically significant difference was observed for the influence of education in a study on the use of maternal health care services in Ethiopia, even after adjusting for the effects of other variables (Dane 2010). Additionally, compared to women whose partners had no education, those who had a secondary or higher education had twice the likelihood of delivering their babies with professional help. In Uganda, the authors of a study that examined the socioeconomic demographic factors influencing the use of contraception using data from the 2006 and 2011 Health Surveys discovered that gender, educational achievement, and the likelihood of taking contraception were all related.

A woman was more likely to report using current methods of contraception if she had higher education. The use of modern contraceptives was reported by more than one-third of women in this age group who had completed secondary or higher education, but significantly fewer women who had no formal education. Mushom, Ndugga, and Assime (2013).

In a similar vein, Vallieres et al. (2013) discovered a noteworthy distinction in skilled birth attendance between Ugandan household heads with only a primary education and those with a secondary education or above. Those with a secondary or higher level of education were at a significantly higher risk of seeking a skilled birth attendant. In terms of health care delivery, there was a notable difference between male heads of households with only a primary education and those with a secondary or higher education. Those with higher education were also much more likely to give birth in a facility that was healthy.

Education gives both men and women the ability to make their own health decisions and the understanding of the availability and advantages of maternal health services. We therefore expect both men and women to be uneducated. In terms of other reproductive health treatments, like contraception, these trends align with those noted.

According to Shrestha et al. (2014), literate males make well-informed decisions, particularly in emergency situations where one's choices are crucial. Additionally, they determined that awareness is the element that enhances the men's educational background. They added that by planning a pregnancy, having safer sex, and going to MCH clinics with their wife, they may raise awareness among their neighbors and inspire them to take similar steps

2.4 Literature summary

A high maternal mortality rate in the state is thought to be caused by sociocultural and traditional practices, such as the use of herbs, forced marriage, early marriage, child spacing, female genital mutilation, low levels of education during childbirth, and traditional gender discrimination, according to the literature reviewed by the majority of scholars (Geografia 2014, Okutu 2011, Asimwe 2010).

Men participate in reproductive decision-making despite their lack of health knowledge, and in societies where power is distributed equally, they may even have significant control over their partners' sexuality (Green et al. 2012, Schiller et al. 2011 Ghararo 2000, UNFPA 2000, Adewuy 1999, Thaddeus and Maine 1994).

CHAPTER THREE

METHODOLOGY

3.0. INTRODUCTION.

This chapter contains the introduction, study design, survey population, sample selection, sample techniques, data collection methods and data analysis and data processing.

3.1. RESEARCH DESIGN.

The researcher used a descriptive research design using both qualitative and quantitative methods to conduct the study. While the qualitative technique was used to provide qualitative information, the quantitative approach was used to generate numerical data or data that could be transformed into numbers for a statistical review.

3.2. AREA OF STUDY.

The study was conducted in the Wakiso District at Kasangatti Health Center IV, Kasangati Town Council. This resulted from the low level of male participation in maternal health care provided by the facility in this location.

3.3. STUDY POPULATION

The study population was 58 and it comprised of doctors, clinical officer, nurses, counsellors and support staff.

3.4. SAMPLE SIZE

Using the Kricje and Morgan table 1970, a sample size of 50 was obtained.

Table 1: sample size and population

CATEGORY	Population	Sample size
DOCTORS	3	3

Clinical officers	6	5
NURSES	24	20
COUNSELLORS	23	20
Support staff	2	2
TOTAL	58	50

Source; primary data 2024

3.5. SAMPLING TECHNIQUES

Simple random sampling technique of data collection was used for mainly Head of department because it gave the researcher opportunity to access all members of the population with no bias and they have equal chance of being included in the sample.

3.6. DATA COLLECTION METHODS

The researcher used different data collection methods during the study. These methods included questionnaires survey, interviews and observation.

3.6.1. Interview method.

This is a way to get additional information and knowledge from the respondents. This is an in-person discussion between the responder and the researcher. More specific information regarding the low level of male involvement in maternal health within the study area is needed for this strategy.

3.6.2. Survey method

A research questionnaire is a tool used to collect data from a large sample, typically the population. The questionnaire was chosen above other tools because it allowed for the collection of data from sizable samples, eliminated biases because it was presented on paper, maintained anonymity, and was saved on time. Appendix II's structured questionnaire is based on the particular goals to supply the information needed to address the study questions.

3.6.3. Observation method.

Necked eyes must be used with this technique. In other words, the researcher was able to observe firsthand the low male participation in maternal health programs, particularly in the postnatal and antenatal care when women could visit alone without their husbands' presence.

3.7. DATA PROCESSING AND ANALYSIS.

3.7.1. Data processing.

This is referred to a series of action or step performed on data to verify, organise, transform, integrate and extract data in an appropriate output form for subsequent use.

3.7.2. Data editing

In order to minimize potential bias and guarantee consistent estimates that result in a clear analysis of the data set by correcting inconsistent data using the procedures used in data collection, the researcher employed this strategy. to provide the necessary pertinent details.

3.7.3. Data coding.

In order to create a coherent, unified category, the researcher changed the information or observations that were gathered during this phase. To give a methodical explanation of the data that was captured, the gathered data was summarized. This improved the accuracy of the data entry and collection. Leveled and qualitatively organized data allowed for easy identification.

3.7.4. Data tabulation.

The researcher systematically presented data into rows and columns in order to facilitate comparison and statistical analysis. This facilitated comparison by bringing related information close to each other and this helped in statistical analysis and interpretation.

3.8. ETHICAL CONSIDERATION

During data collecting, the researcher wore appropriate clothing since it made her more respectable to the respondent and made her job easier.

The supervisor granted the researcher authorization and authority to gather data from the respondents without causing hardship to the community members.

3.9. LIMITATIONS OF THE STUDY.

Due to the fact that I was unable to speak with the respondents directly, particularly during the focus group discussions, and had to rely on their interpretations, the language barrier posed a significant challenge to this study in terms of time, money, and staff.

CHAPTER FOUR

PRESENTATION AND INTERPRETATION OF FINDINGS

4.0 Introduction

This chapter focuses on the demographic information of the respondents, presentations, interpretation and discussions of findings. The presentations were done based on the research questions.

4.1 Response rate

The percentage of the sample that engaged as planned in every step of the study process is known as the completion rate. Of the 42 questionnaires that were distributed, 31 (62%) were returned, and 6 (12% of the total) of the 8 respondents who were targeted for interviews were accessible. Therefore, it was decided that the 74% response rate was sufficient for the study.

Table 2: Response rate

Instrument	Target	Actual	Percentage
Questionnaire	42	31	62%
Interviews	08	6	12%
Total	50	39	74%

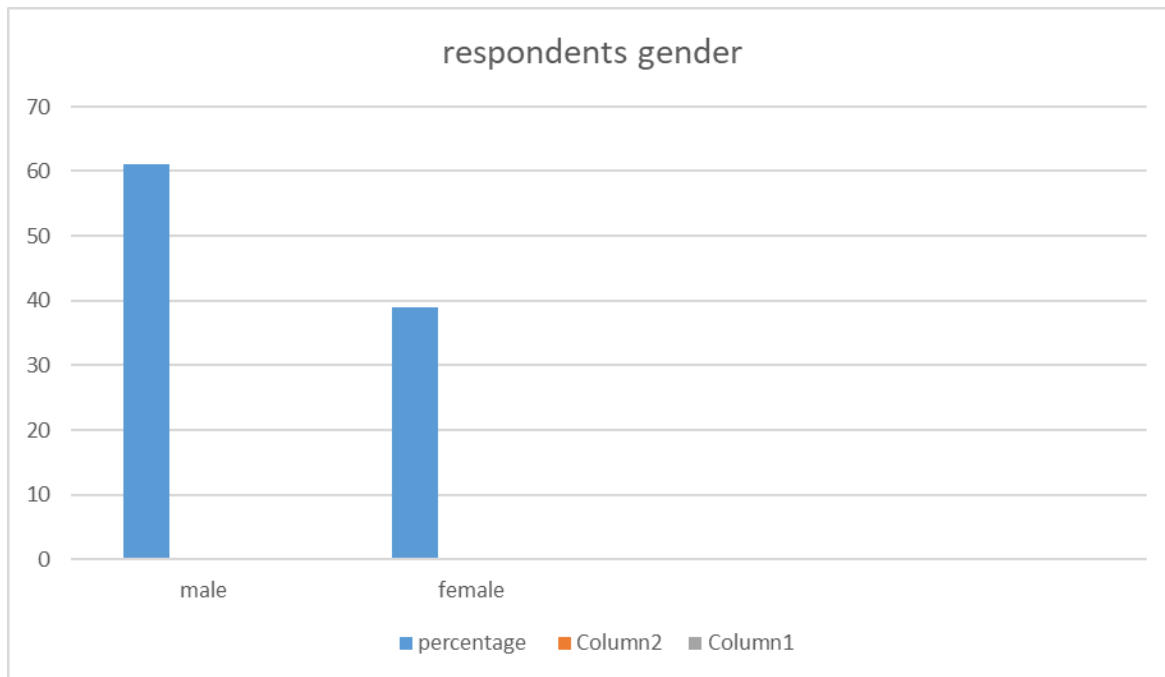
Source: primary data 2024

4.2 Demographic Information of the respondents

The demographic information of the respondents was based on their gender, level of education, age and experience.

4.2.1 Gender

To establish the gender of the respondents, they were asked to indicate the same. The data is presented in figure 1 below.



Source: primary data 2024

According to the findings in figure.1 above a majority of the respondents 61% were male while 31% were female. This implies that the study was gender sensitive.

4.3.3 Highest level of education

Table 4; Respondents highest level of education

Level of education	Frequency	Percentage
Masters	01	2.5 %
Bachelors	08	20.5 %
Diploma	17	43.6 %
Certificate	13	33.3 %
Total	39	100

Source; primary data 2024

Data on the level of education of the respondents indicated that a majority of respondents

43.6 % had diploma level of education, 33.3% had diploma in education, 20.5 % had bachelors degree in and only 2.5% had masters degrees. The data shows that all the respondents had attained some level of education.

4.4 KEY STUDY FINDINGS

4.4.1 Socio- cultural norms and hindrance male involvement in maternal health in Wakiso district.

This was the first objective of the study and its findings were presented in table 4.1 below

Table 4.1 ; Descriptive statistics on Socio- cultural norms and hindrance male involvement in maternal health in Wakiso district(n=31)

Code	Statement	Strongly agree(5)	Agree(4)	Not sure (3)	Disagree(2)	Strongly disagree
SCN01	In my cultures, a man should not live together with his pregnant wife	12.9% (4)	19.4%(6)	16.1% (5)	38.7% (12)	12.9% (04)
SCN02	In my culture pregnant woman should stay with the grand parents	19.4% (6)	9.7%(3)	22.6 %(7)	29 %(9)	19.4%(6)
SCN03	In my cultures, once the woman gets pregnant the husband should look for another wife	6.4 %(2)	3.2 %(1)	16.1 %(5)	29. %(9)	45.2 %(14)
SCN04	Cultural belief in my society dictate on	22.6 %(7)	45.2 %(14)	9.7% (3)	9.7% (3)	12.9%(4)

	pregnant mothers feeding practices					
SCN05	In my culture Expectant mothers prefer to deliver at home with the assistance of traditional birth attendants	3.2 %(1)	22.6 %(7)	9.7%(3)	35.9% (14)	15.4% (6)

Source: primary data 2024

In contrast to 32.3% who agreed with the statement, the majority of respondents (51.6%) believed that a man should not reside with his pregnant wife in their culture (see table 4.1). This statement's mean score was 2.8, indicating a moderate degree of agreement.

Regarding the recommendation that expectant mothers remain with their grandparents, 48.4% of respondents agreed with it, while 22.6% were unsure and 29.1% opposed. This statement's mean score was 2.8, which denotes a modest degree of agreement.

Compared to 9.6% who agreed, 74.2% of respondents disagreed with the statement that in certain cultures, the husband should find a new wife when the woman becomes pregnant. A relatively low degree of agreement was indicated by the statement's mean of 1.96.

67.8% of respondents agreed with the statement that cultural beliefs in society dictate how pregnant moms should feed their unborn children, compared to 22.6% who disagreed. A significant degree of agreement was indicated by the mean of 3.5, which corroborated this. Out of the respondents, 51.3% disagreed with the assertion that expectant mothers prefer to give birth at home with the help of traditional birth attendants, compared to 25.8% who agreed. A low degree of agreement with the statement was indicated by the mean of 2.4.

According to the aforementioned research on sociocultural norms and the barriers to male

involvement in maternal health in the Wakiso District, the main cultural norms that do not substantially impede male involvement are the following: cultural beliefs that society dictates how pregnant mothers should feed, that pregnant women should stay with their grandparents, and that men should not live with their pregnant wives.

4.4 .2 Lack of awareness hindrance of male involvement in maternal health in Wakiso district.

This was the second objective of the study and its findings were presented in table 4.2 below.

Table 4.2 ; Descriptive statistics on Lack of awareness and hindrance of male involvement in maternal health in Wakiso district.(n=31)

Code	Statement	Strongly agree	Agree	Not sure	Disagree
LW1	Men play an important role in ensuring that their pregnant partner receives proper care during and after pregnancy.	6.4 % (2)	19.4% (6)	9.7% (3)	41.9 % (13)
LW2	Most men are involved in reproductive health decision making in society	16.1%(5)	15.4%(6)	9.7%(3)	48.4%(15)
LW3	Family planning programs which targets women will have a higher probability of success if the male partners involvement	45%(14)	22.6%(7)	9.7%(3)	15.4%(6)

LW4	Involving men in reproductive health is likely to improve support for their partners	19.4%(6)	25.8%(8)	19.4%(6)	19.4% (6)
LW5	Men support their wives to progress through pregnancy and child birth	6.4%(2)	25.8% (8)	12.9%(4)	54.8%(17)

Source: primary data 2024

The study's findings, as shown in table 4.2 above, show that most respondents 64.3% disagreed with the assertion that men are crucial in making sure their pregnant partner gets the care they need both during and after pregnancy, while 25.8% agreed. The average response, which indicated a low degree of agreement, was 2.4.

Of those surveyed, the majority (54.8%) disagreed with the assertion that the majority of males participate in reproductive health decision-making in society, while 31.5% agreed. This statement has a mean of 2.9, which suggests that people agree with it to a modest degree. Regarding the assertion that family planning programs aimed at women will be more likely to succeed if male partners are involved, the majority of respondents—67.6%—agreed with the statement, compared to 18.6% who disagreed. With a mean of 3.8, this statement showed a high degree of agreement.

Of those surveyed, 45.2% agreed with the statement that involving men in reproductive health is likely to boost support for their partners, 19.4% were undecided, and 35.5% were undecided. A significant degree of agreement with the statement was shown by the mean response, which was 3.0.

In summary, awareness of mens role in reproductive health decision making, family planning programs and men involvement in reproductive health would break the barriers to male involvement in maternal health in Wakiso district.

4.4.3 Level of education and hindrance of male involvement in maternal health in Wakiso district

This was the third objective of the study and its findings were presented in table 4.3 below.

Table 4.3: Descriptive statistics on the Level of education and hindrance of male involvement in maternal health in Wakiso district(n=31)

CODE	Statement	Strongly agree	Agree	Not sure
LE1	Educated men to use Antenatal care frequently	6.4%(2)	22.6%(7)	12.9%(4)
LE2	Mens education is positively associated with other aspects of maternal care.	9.7%(3)	25.8%(8)	3.2%(1)
LE3	Men and women with higher education use Antenatal care than those with no education.	6.4%(2)	51.6%(16)	12.8%(4)
LE4	There is a significant difference in skilled birth attendance between heads of households with lower education and those with higher education	16.1%(5)	29%(9)	19.4%(6)

LE5	Education has empowered men about the availability and benefits of maternal health services	19.4%(6)	29%(9)	9.7%(3)
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Source: primary data 2024

The majority of respondents (58%), as shown in table 4.3 above, disagreed with the statement that educated men use antenatal care frequently, compared to 29% who agreed. A considerable degree of agreement was indicated by the statement's mean of 2.6.

Men's education was not positively correlated with other aspects of maternal care, according to the study. This finding was supported by 61.3% of respondents who disagreed with the statement, compared to just 35.5% who agreed. A mean score of 2.7, which denotes a moderate level of agreement with the statement, further confirmed this.

The majority of respondents (58%), as opposed to 29%, agreed with the assertion that men and women with greater levels of education use antenatal care more frequently than those without any education. A significant degree of agreement was shown by the statement's mean of 3.4.

Of those surveyed, 45.1% agreed that there was a substantial difference in skilled birth attendance between heads of families with lower and higher levels of education, compared to 35.5% who disagreed. A significant degree of agreement was shown by the statement's mean of 3.1.

Lastly, there were differing opinions about educating men about the advantages and accessibility of maternal health services. Of the respondents, 41.9% disagreed with the statement, while 48.4% agreed.

CHAPTER FIVE

SUMMARY AND DISCUSSION OF RESULTS

5.0 Introduction

This chapter presents the summary and discussion of the major findings, in relation with the background and literature review. The researcher's personal views are also included arising observation and interpretation of situations encountered during the study. The conclusions are given based on the findings and consequently, recommendations were made based on the conclusions.

Summary of Findings

5.1.1 Socio- cultural norms and hindrance male involvement in maternal health in Wakiso district.

According to the study, the main cultural norms that prevented men from participating in maternal health were the following: men shouldn't live with their pregnant wives; pregnant women should stay with their grandparents; and cultural beliefs that society dictates how expectant moms should be fed. Nonetheless, cultural beliefs that influence pregnant women's feeding habits were placed highly among all the elements in my society. This suggests that even though the men would want to provide their expectant mothers with a healthy, balanced diet, some foods are forbidden in their society, even though they are nutritious.

5.1.2 Lack of awareness hindrance of male involvement in maternal health in Wakiso district.

The majority of men were unaware that they had a significant role to play in ensuring that their pregnant partners receive appropriate care during and after pregnancy, and that they needed to be involved in reproductive health decision making in society. These findings were derived from the analysis of responses to various statements regarding the lack of awareness that hinders male involvement in maternal health in Wakiso district. In conclusion, the obstacles to male participation in maternal health in Wakiso district would be removed by raising knowledge of men's involvement in reproductive health, family planning initiatives, and reproductive health decision-making.

5.1.3 The Level of education and hindrance of male involvement in maternal health in Wakiso district

The study found that men's education was not positively correlated with other aspects of maternal care, that the level of education of male partners did not affect the use of antenatal care, and that respondents' responses to education empowering men about the availability and advantages of maternal health services were not all the same.

5.2 DISCUSSION OF FINDINGS

5.2. 1 Socio- cultural norms and hindrance male involvement in maternal health in Wakiso district.

According to the study, the main cultural norms that prevented men from participating in maternal health were the following: men shouldn't live with their pregnant wives; pregnant women should stay with their grandparents; and cultural beliefs that society dictates how expectant moms should be fed. However, cultural beliefs about pregnant women's feeding practices were identified as one of the most important elements in my society. This suggests

that even though the men would want to provide their expectant mothers with a healthy, balanced diet, some foods are forbidden in their society, even though they are nutritious.

These results are consistent with those of Geografia (2014), who investigated the sociocultural and traditional practices related to maternal health in Sokoto State, Nigeria. Geografia found that custom-inspired practices and norms, including unattended childbirth, low educational attainment, taking a hot bath during childbirth, using herbs, forced marriage, early marriage, spacing children, female genital mutilation, and traditional gender discrimination, have a significant impact on maternal health and are thought to be the cause of the high maternal mortality rate in the state.

5. 2.2 Lack of awareness hindrance of male involvement in maternal health in Wakiso district

The majority of men were unaware that they had a significant role to play in ensuring that their pregnant partners receive appropriate care during and after pregnancy, and that they needed to be involved in reproductive health decision making in society. These findings were derived from the analysis of responses to various statements regarding the lack of awareness that hinders male involvement in maternal health in Wakiso district. In conclusion, the obstacles to male participation in maternal health in Wakiso district would be removed by raising knowledge of men's involvement in reproductive health, family planning initiatives, and reproductive health decision-making.

Biddlecoman and Fapohunfa (1998) provided support for these findings by demonstrating that family planning initiatives aimed at women are more likely to succeed if they also promote male participation. However, this study's findings contradict those of researchers like Carter (2002) and Matsuyama (2002), who found that men serve as gatekeepers to women's health-seeking behaviors and use of health services in a variety of contexts, despite their low levels of health knowledge.

5.2. 3 The Level of education and hindrance of male involvement in maternal health in Wakiso district

The study found that the usage of antenatal care was unaffected by the educational attainment of the male partners. The findings contradict those of Celik and Hotchkiss (2000), who demonstrated that the use of maternal care services is increased by the education of both men and women. They also found that educated men and women were more likely than uneducated women to use antenatal care, to use it early and frequently, and to use medical facilities and trained providers.

Finally, there were differing responses from the respondents about education that empowers men about the availability and advantages of maternal health services. It was also determined that men's education was not positively connected with other components of maternal care. These results contradict those of the 2011 Ethiopia DHS, which showed that between 70 and 72 percent of newborns to moms with some secondary education were attended by a healthy facility, but just 5 percent of births to mothers with no education were.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the conclusions and recommendations based on the study findings and objectives.

6.1 Conclusion

The following conclusions were drawn from the discussion of the results for each of the objectives:

Pregnant women's feeding habits are governed by cultural ideas in the community, which has a detrimental effect on the health of the mother. In Wakiso area, it was determined that sociocultural norms were a moderate barrier to men's participation in maternal health.

It was also determined that there was still a lack of knowledge regarding family planning programs, men's involvement in reproductive health, and men's role in reproductive health decision-making. Therefore, increasing awareness would remove the obstacles preventing males from participating in maternal health in the Wakiso district.

The study ultimately found no favorable correlation between the male partners' educational attainment and other facets of maternal care.

6.2 Recommendations

On the basis of the above findings and conclusions, the following recommendations were made:

There is need to do carry out empowerment to men about the availability and benefits of maternal health services there were mixed reactions among the respondents

The village health teams should be facilitated so that they can carry out door to door maternal health education so as to enlighten both men and women on their roles.

The cultural leaders should be engaged on advocacy for better among expectant mothers so that cultural institutions can adjust some of the existing norms for the benefit of the pregnant mothers.

The health workers should always insist on pregnant women going for antenatal and prenatal care with their partners so that both of them get educated on their roles.

Family Counselling and Guidance services need to be effected for couples so as to make them understand their respective roles during prenatal and antenatal care.

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APEDDICIES

APPENDIX I.: CONSENT LETTER UGANDA CHRISTIAN UNVERSITY

P.O BOX 4,,

MUKONO, UGANDA

15TH /JULY/ 2024

THE RESPONDENTS,

KASANGANTI HEALTH CENTRE IV,

KASANGANTTI TOWN COUNCIL,

WAKISODISTRICT.

Dear sir /madam,

RE: INTRODUCTION OF THE RESEARCHER

I am by names of AGUNYO NEPILU PEACE currently a student of Uganda Christian University pursuing a Bachelor of social work and social Administration . I am carrying out a practical research on the factors that hinders male involvement in maternal health issues at Mpigi health centre IV Mpigi District. The research is only meant for Academic purposes and any information obtained or veiled to me will be treated with confidentiality. This will be done through interview guide, Observation checklist, and focus group discussions.

Thanks

Yours faithfully,

AGUNYO PEACE NEPILU

.....

QUESTIONNAIRE TO ASSESS THE FACTORS THAT HINDERS MALE INVOLVEMENT IN MATERNAL HEALTH ISSUES AT MPIGI HEALTH CENTRE IV MPIGI DISTRICT

SECTION A: DEMOGRAPHIC CHARACTERISTICS

NAME:

SEX:

VILLAGE:

OCCUPATION:

EDUCATIONAL LEVELS:

SECTION B; Socio- cultural norms that hinder male involvement in maternal health in Wakiso district.

Statement	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
in some cultures, a man should not live together with his pregnant wife					
In some cultures, a man should not live together with his present wife					

In my culture pregnant woman should stay with the grand parents					
In some cultures, once the woman gets pregnant the husband should look for another wife					
Cultural belief in my society dictate on pregnant mothers feeding practices					
Expectant mothers are reluctant in seeking health care services but preferred to deliver at home with the assistance of traditional birth attendants					

SECTION C; LACK OF AWARENESS HINDER AND MALE INVOLVEMENT IN MATERNAL HEALTH IN WAKISO DISTRICT.

Statement	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
Men should play an important role in ensuring that their pregnant partner receives proper care during and after pregnancy.					
Thus men are involved in reproductive decision					

making in society					
men are more likely than women to control sexual interaction and reproductive health					
Family planning programs which targets women will have a higher probability of success if the male partners involvement					
Involving men in reproductive health is likely to improve support for their partners					
Male support is necessary for women to progress through pregnancy and child birth					

SECTION D; LEVEL OF EDUCATION HINDER AND MALE INVOLVEMENT IN MATERNAL HEALTH IN WAKISO DISTRICT.

Statement	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
Educated men more likely to use Antenatal care frequently					
Mens education is positively associated with other aspects of maternal care.					
Men and women with higher education use Antenatal care than those with no education.					
There is a significant difference in skilled birth attendance between heads of households with lower education and those with higher education					
Education has empowered men about the availability and benefits of maternal health services					

APPENDIX II: INTERVIEW GUIDE

TOPIC: AN INVESTIGATION ON THE FACTORS HINDERING MALE

INVOLVEMENT IN MATERNAL HEALTH AT MPIGI HEALTH CENTRE IV.

SECTION A

BIO DATA

NAME:

SEX:

VILLAGE:

OCCUPATION:

EDUCATIONAL LEVELS:

SECTION B

1. What do you understand by male involvement / Participation in maternal health issues?
2. How do you think men should be involved in maternal health issues?
3. What roles do men in this area currently play during maternal health issues?
4. What can you say about the current level of male involvement in maternal issues in this area?
5. In addition to the roles men in this Area, what do you think they can do more to assist you during pregnancy?
6. Can the obstacles be removed?

Thanks for your time and your kind participation