FACTORS AFFECTING MALE PARTNER INVOLVEMENT IN MCH AMONG FAMILIES IN HUMANITARIAN SETTINGS. A CASE STUDY OF IMVEPI REFUGEE CAMP

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Abstract

A study on “Factors Affecting Male Partner Involvement in MCH among Families in Humanitarian Settings: a case study of Imvepi refugee camp”. It aimed at addressing the following objectives: i) To establish the level of male partner involvement in maternal and newborn health among families in Imvepi refugee settlement, ii) To identify the perceived facilitators/enablers of male partner involvement in maternal and newborn health among South Sudanese in Imvepi refugee settlement, and iii) To establish the perceived barriers that hinder male partners from actively participating in maternal and newborn health.

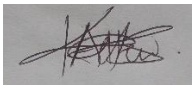
The study used a descriptive cross-sectional community-based survey, that employed both qualitative and quantitative data collection methods. Data was collected through one-on-one interviews, Focus Group Discussions and Key Informant interviews using questionnaires and semi-structured interview schedules with a response rate of 97.6%. Stratified random sampling, Simple random sampling and Purposive sampling techniques were used accordingly to sample respondents. Qualitative data was transcribed verbatim in a local language and then translated into English language. However, quantitative data was analyzed using Statistical Package for Social Scientists version 20.0 into frequencies and percentages.

It was noted that men in humanitarian settings were more involved than their counterparts due to increased knowledge of obstetric and newborn dangers signs among men as well as accessibility of healthcare facilities. On the contrary, men were still hindered by financial constraints and cultural connotations surrounding childbirth. In the quest to reduce preventable maternal and infant deaths coupled with the influx of refugees, there is need for governments to reduce out of pocket expenditures associated with healthcare services and invest in sensitizing communities on the critical role played by all stakeholders.

Declaration

I **Namazzi Allen**, declare that the work submitted herein in this dissertation is my own work except where it has been cleared indicated by referencing. I recognize the university's policy on plagiarism and certify that the work has not been submitted for any other degree or professional qualification from Uganda Christian University or any other university or institution of learning. A reference list has been provided for all supporting literature and resources.

Student's name, Allen Namazzi

Signature 

Date 9/06/2023.

Supervisor's name, Mr. David Nangoley

Signature 

Date 28/03/2024.

Approval from the Supervisor

I David Nangoley the supervisor of Allen Namazzi's research work on "Factors affecting male partner involvement in MCH among families in humanitarian settings. A case study of Imvepi refugee camp", acknowledge that the research work embodied in this thesis was carried out under my supervision and it is ready for submission in partial fulfillment for the requirements for the award of the master's degree of Public Health of Uganda Christian University.

Signature  Date: **28th March 2023.**

David Nangoley

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List of acronyms and abbreviations

ANC – Antenatal Care

CAPI – Computer Assisted Personal Interviewing

FGDs – Focus Group Discussions

HIV – Human Deficiency Syndrome

HSDP – Health Sector Development Plan

IRC –International Rescue Committee

KIIs – Key Informant Interviews

MCH – Maternal and Child Health

MHC- Maternal Health Care

MOH – Ministry of Health

MPI – Male Partner Involvement

NICU – Neonatal Intensive Care Unit

OPM – Office of the Prime Minister

PNC – Post Natal Care

SPSS – Statistical Package for Social Sciences

SOPs – Standard Operating Procedures

RWCs – Refugee Welfare Councils

TPB – Theory of Planned Behavior

UCU – Uganda Christian University

UNFPA – United Nations Population Fund

UNHCR –United Nations High Commissioner for Refuge

1.0 INTRODUCTION

Globally, men have continued to prioritize the role of a bread winner to being an involved father despite emphasis of male partner involvement in maternal and child health plus its associated positive outcomes. Whereas only 6% of men in Uganda had been able to embrace the role of being an involved father (Kariuki and Seruwagi, 2016), the situation was worsened by the influx of refugees. Merry, Pelaez and Edwards (2017), noted that fathers struggled with significant shifts in gender roles and social expectations arising from breakdown of family structures due migration. In a humanitarian setting where only 29% of the refugees were employed (UNHCR 2021), the study sought to establish factors that affect male partner involvement in maternal and newborn health.

1.1. Background

Globally, there had been special recognition and emphasis on the importance of involving men in sexual and reproductive health, as well as maternal and child health programs. Since the early 1990s as highlighted in the International Conference on Population and Development (1994), Fourth World Conference on Women (1995) and the 48th UN Commission on the Status of Women (2004), the role of men was given due recognition.

There was increasing support to involve fathers in maternal and child health programs from the World Health Organization (WHO), United Nations Population Fund (UNFPA), national governments, and non-governmental organizations (NGOs). To support that initiative, the government of Uganda launched a national male involvement strategy in November 2014 to emphasize participation of men in everything pertaining maternal and child health including healthy feeding, sanitation, immunization, family planning, prevention of malaria and HIV/AIDS. This

was legally reinforced by the formation of policies to promote and advance active participation of men, for example, The Uganda Gender Policy of 2007, the National Policy for Elimination of Gender-Based Violence, and the National Infant and Young Child Feeding program, the Male Action Groups (MAGs) etc.

That recognition proved effective in improving self-care of the woman, improving home care practices for the woman and newborn; and improving use of skilled care during pregnancy, childbirth and the postnatal period for women and newborns as reported by Tokhi, Comrie-Thomson, Davis, Portela, Chersich, and Luchters (2018). Additionally, Olajide, Wilson, Abshire, Mejia-Lancheros and Schetter (2020), reported that increased father involvement and more engaged styles of father-infant interactions were linked to positive family outcomes and crucial for the reduction of infant and maternal mortality.

Despite global recognition, policy emphasis and associated positive outcomes of male partner participation in maternal and child health, it had been wanting globally, especially in low- and middle-income countries, where women have limited access to economic resources and decision-making power (Prerna, Fisher, Seruwagi and Taddese 2020). Whereas Sub-Saharan Africa account for the larger share of preventable maternal and child deaths, they had reported equivalently low levels of male participation; 54% in Tanzania (Natai, Gervas, Sikira, Leyaro, Mfanga, and Yussuf 2020), 29.8% in Ethiopia (Ayalew, Gebrie, Geja, and Beyene 2020), 6% in Wakiso District, Uganda (Kariuki and Seruwagi 2016) and 26% in Nairobi, Kenya (Aluisio et al, 2017). The patriarchal nature of communities of Sub-Saharan region socio-culturally placed men as key decision makers. That largely explained the high number of preventable maternal and child deaths as being attributed to decision

makers who could not make informed choices because for long they were precluded from reproductive, maternal and child health education (Amanual, 2018).

On the other hand, Shyama et al, (2016) recognized that the first three indicators of SDG 3 (*Reduce maternal mortality; End all preventable deaths under five years of age and Fight communicable diseases*) could not be met without urgent action in humanitarian settings as evidence-based guidelines for interventions aimed at improving maternal and newborn health in humanitarian settings could not be achieved since limited information existed on men who were the key decision makers. With over 82.4 million people forcibly displaced resulting from persecution, conflict, violence, human rights violations, or events seriously disturbing public order globally (UNHCR 2019) and another 235 million in need of humanitarian assistance (Global Humanitarian Overview 2021), there was urgent need to design contextual interventions to address health issues in humanitarian settings.

The situation was worsened by the fact that 85% of displaced persons were hosted by developing countries where health systems were severely constrained with unacceptably high maternal deaths majorly resulting from preventable causes (UNHCR Global trends 2020). According to IRC (2019), nine out of the ten refugee hosting countries were in developing regions and 3 of these countries were classified as “least developed”.

Globally, Turkey was the largest refugee hosting country with over 3.6 million refugees, followed by Colombia with 1.7 million. Although Uganda was reported to be having one of the lowest male partner engagement rates of 6% (Kariuki and Seruwagi 2016) as well as the highest neonatal mortality rate in Sub Saharan region (Asiimwe, Nyegenye and Muyingo 2019), it was the fourth refugee hosting country globally with 1.4 million refugees (UNHCR Global trends 2020). According to UNHCR

Africa, Uganda hosts over one million refugees from South Sudan - a country with one of the worst reproductive health situations in the world. Sumit, Rial, Matere, Dieleman, Broerse and Kok (2016) reported that South Sudan had a maternal mortality ratio of 789 per 100,000 live births, contraceptive prevalence rate of 4.7% and a teenage pregnancy rate of 34.5%.

The 1994 International Conference on Population and Development advocated for shared responsibility of reproductive health among men and women as a key intervention to improve maternal and child health outcomes. Despite insufficient evidence on the impact of male involvement on maternal deaths, their involvement had shown benefits for other maternal and child health outcomes and was therefore highly commended (WHO 2015). According to Shefaly and Lina (2019), male partner involvement was largely influenced by spousal relationships, whereby women with health spousal relationships were safer sharing their feelings around pregnancy and childbirth and vice versa. Unfortunately, conflict and post-conflict settings were characterized by exceptional relationships and informal marriage patterns resulting from fundamental shifts in economies, broken family relationships, and communication combined with structural changes encountered in settlements. These changes had greatly affected the views, understanding, and behaviors of youth about marital relationships (Schlecht, Rowley, and Babirye 2013), hence the need to understand the context of a humanitarian setting to identify tailor-made and contextualized or locally appropriate interventions or approaches to male partner involvement. The study was conducted among refugees in Imvepi refugee settlement in northern Uganda where 98% of the refugees were South Sudanese.

1.2 Problem statement

Uganda was reported to be the 4th largest refugee hosting country globally (UNHCR Global trends 2020); it had also maintained the highest neonatal mortality rate in the region for the last 10 years (Asiimwe et al, 2019). Uganda's largest refugee population came from a country (South Sudan) with one of the worst reproductive health situations in the world with a maternal mortality ratio of 789 per 100,000 and a teenage pregnancy rate of 34.5% (Sumit et al, 2016). Sumit et al, (2016), further noted that social expectations and household responsibilities of men in South Sudan ceased along with traditional marriage practices. This had been worsened by the effects of migration on family structures, relationships, gender roles, and social expectations (Merry et al, 2017).

Whereas no or limited studies had been conducted on male partner involvement particularly among refugees, Kwiringira, Mutabazi, Mugumya, Kaweesi, Munube, and Rujumba (2018) reported South Sudanese as one of the refugee ethnic groups in Uganda most affected by GBV including being deliberately infected by HIV.

In other studies, it was noted that men expressed desire to be more engaged in family life, but they were being 'crushed' between playing the role of an involved father and a household breadwinner (Shefaly and Lina 2019). The study aimed at establishing perceived factors affecting male partner involvement in maternal and newborn health among South Sudanese refugees in Imvepi camp given that only 19.9% of these refugees were employed (Uganda - Refugee Statistics July 2021 - Imvepi).

1.3. Justification of the study

While it was uncommon to find men accompanying their partners during antenatal care and childbirth in sub-Saharan Africa, socio-culturally, men still exercised a lot of power in decision-making in the family. Involvement of men partly addressed two of the three delays *(delay in decision-making to seek medical care and delay in reaching the service delivery point due to lack of transport)* responsible for many maternal deaths (Amanual, 2018). Failure to actively incorporate men in maternal and child health promotion, prevention and care programs had negatively influenced the success of implemented programs. A study to establish factors that affect the involvement of key stakeholders was a serious factor which could not be ignored in the pursuit to reduce maternal and child mortality rates.

1.4. Significance of the study

The unacceptably high maternal and neonatal mortality rates in Uganda, coupled with the large influx of refugees mainly from South Sudan a country with one of the weakest healthcare systems characterized by severe deficits of health workers and nonfunctional health facilities (South Sudan, HSDP 2012), called for ardent need to strengthen healthcare delivery in Uganda.

46% of women and girls in humanitarian settings were vulnerable to gender-based violence, and 35% were reported to have experienced sexual abusive acts like physical and sexual assault, mass rape, involuntary prostitution, sexual slavery, unwanted pregnancies, FGM, forced marriages, and transactional sex (Jensen, 2019). This situation had been exacerbated by the COVID 19 financial crisis (Nakkazi 2021). Despite improvement in healthcare service delivery in refugee settlements, there was urgent need to assess the contribution of key stakeholders in healthcare for effective utilization. The study explored factors that affected the contribution

of men as key decision makers at family level in maternal and newborn healthcare. The results of the study were to be used by policy makers and healthcare programmers in designing contextual interventions in collaboration with community members, specifically, fathers and community leaders who were knowledgeable of the social norms, structures, and challenges of the community in improving quality of life among mothers and children within Imvepi refugee camp and beyond. Additionally, the study findings were to aid further research studies towards improving the lives of displaced persons.

1.5 Objectives of the study

1.5.1. General Objective

To assess factors affecting male involvement in maternal and newborn health care among South Sudanese refugees in Imvepi refugee settlement

1.5.2 Specific Objectives

1. To establish the level of male partner involvement in maternal and newborn health among families in selected zones in Imvepi refugee settlement.
2. To identify the perceived facilitators/enablers of male partner involvement in maternal and newborn health among families in South Sudanese selected zones in Imvepi refugee settlement.
3. To establish the perceived barriers that hinder male partners from actively participating in maternal and newborn health among families in selected zones in Imvepi refugee settlement.

1.6 Research Questions

1. What is the level of involvement of South Sudanese male partners in maternal and newborn health care?

2. What are the perceived facilitators enable men in humanitarian settings to participate in maternal and newborn health care?

2. What are the perceived factors that hinder to men in humanitarian settings from participating in maternal and newborn health care?

1.7 Scope of the Study

1.7.1 Geographical Scope

The study was conducted in Imvepi refugee settlement located in Terego District, Northern Uganda. The settlement had 69,198 (88% being women and children) persons distributed in 4 zones (Uganda - Refugee Statistics March 2021 - Imvepi). From previous studies, male partner involvement had a connotation on socio cultural differences, the study focused on only refugees from South Sudan hence the choice of Imvepi refugee settlement where 98% of the refugees came from South Sudan (UNHCR 2021).

For generalizability, the study focused on 2 zones which were purposively selected to represent rural and urban populations. Urban populations included zones surrounding (within 3 kms) service centers like health facilities, schools, distribution centers etc., whereas those within 4 kms and above away from service centers were be considered rural. This classification was meant to assess the effect of distance to a health center as a hindrance to male partner engagement as reported by Kabanga, Chibwae, Basinda and Morona (2019).

1.7.2 Time Scope

The study was conducted between August 2022 - March 2023. Data was collected from November 2022 to February 2023 whereas data analysis and reporting writing were concluded in April 2023. The time frame enabled the researcher to submit the

research report and prepare for preceding steps (defense) within the study period allocated by Uganda Christian University for Master of Public Health.

1.7.3 Content Scope

In terms of content, the study focused on factors affecting male involvement in maternal and newborn health care among Sudanese refugees in Imvepi refugee settlement. The study was limited to level of male partner involvement in maternal and newborn health among families, perceived facilitators/enablers of male partner involvement in maternal and newborn health among families, and perceived barriers that deterred men from actively participating in maternal and newborn health among families in selected zones in Imvepi refugee settlement. Despite great improvement in healthcare provision in humanitarian settings, preventable pregnancy-related mortality rates had remained high - 1.9 times higher than the world average (UNFPA 2015). This called for further research into causes of preventable maternal and child deaths among persons in humanitarian settings.

1.8 Theoretical framework

Male involvement in maternal and newborn health was determined by an individual's intention which was largely dependent on one's beliefs and self-confidence to perform the behavior and therefore, it could be better understood using the Theory of Planned Behavior (TPB). This theory was developed in 1991 by Icek Ajzen as an attempt to predict human behavior. It stated that intention, which was the most important determinant of behavior, depends on three conceptually independent constructs namely attitude (*the degree to which a person has positive or negative feelings about a behavior/male involvement in this case*), subjective norms (*social pressures or perception regarding a behavior/male involvement*), and perceived behavioral control (*person's perception of the ease*

with which a behavior was performed). According to the TPB, a positive attitude alone was not enough to shape decisions and behavior; but predominant social norms and one's beliefs about own ability to act, also affected the individual's decision and action.

Intention was high if one.

1) had positive attitudes about their involvement

2) believed that community norms favored their involvement and

3) believed that they can be involved in maternal and newborn health.

The decision to take on a behavior (intention) as reflected by the three independent constructs in the theory of planned behavior was indirectly influenced by various factors for example attitudes toward a certain behavior (in this case male engagement) was influenced by beliefs on what was entailed in execution of the behavior and results of the behavior. Subjective norms were influenced by beliefs about social standards and motivation to comply with those norms. Perceived behavioral control was influenced by the presence or lack of things that would make it easier or harder to perform the behavior.

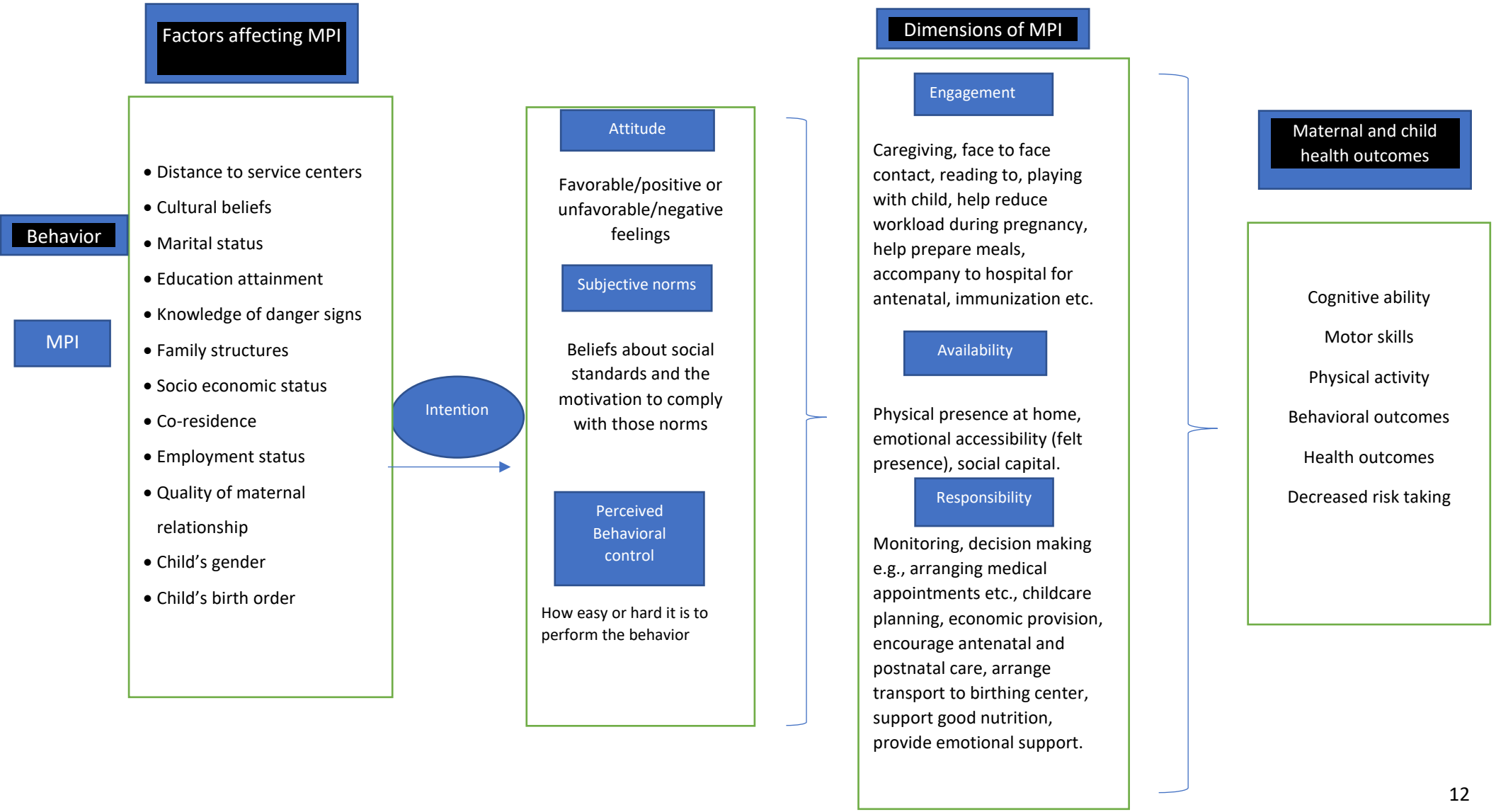
TPB constructs directly affected male partner involvement under the 3 dimensions of engagement, availability, and responsibility (Lamb et al, 1985). Engagement was defined as any direct contact with the child and mother and involved activities like care giving, reading books to the baby, playing with the baby, helping with home chores' workload during pregnancy, help with meal preparation and accompanying mother during antenatal clinics, childbirth, postnatal clinics, immunization of the children etc. Engagement also took on other elements like disciplining. According to Lamb's model, the quality of engagement between the father and child impacted the father's level of engagement.

Availability referred to how accessible a father was to both the child and the mother regardless of whether engagement occurred. This included physical presence for example sharing a home together and emotional accessibility which took on the “felt presence” of a father.

Responsibility referred to a father's participation in activities related to decision-making and planning for the family’s wellbeing. Such activities included economic/family provision, scheduling medical appointments, and encouraging good health practices etc.

The decision to choose the TPB framework followed a wide application of the theory to a diversity of domains for predicting, explaining, and conducting behaviour change interventions (Alhamad and Donyai, 2021). Additionally, the three independent constructs of TPB were reported to be significant predictors of behavioral intention in health-related studies: perceived behavioral control by 85.5%, attitude by 81.5% and subjective norm by 74.4%. On the other hand, the TPB had limitations for example there were other variables which had control over actual behaviour but they were not being considered, for example desire, need, fear, threat, mood, and past experience (Ajzen 2021); the theory assumed that the person had attained all the opportunities and the necessary resources required to perform the desired behaviour regardless of intention; it did not take into account environmental or economic factors that influenced a person's intention to perform a behavior. To overcome the limitations mentioned above, the study was carried out in a specific context (humanitarian setting), and it included other variables that influenced behavior (male partner involvement) for example distance to service centers and marital status.

Figure 1: Theoretical framework (Adopted and modified from Karen Glanz & Rimer 2005)



Male partner involvement as a behavior was taken on depending on the effect of the factors that affect intention in one's environment, for example distance to service centers. For example, attitude as a construct of intention in the theory of planned behavior could be affected by the gender of the child (if a father desired a different gender, he was likely to have negative attitudes towards the baby) or if the father was living in an unhealth marital relationship for example one characterized by abuse and violence, he was likely to develop negative attitudes about the baby and the mother.

Subject norm was affected by factors like cultural beliefs around male involvement, family structures and socio-economic status. For example, many African cultures tagged child rearing as a feminine responsibility. Men who embraced their cultural beliefs were less likely to be involved in ANC, or accompany women to hospital etc. Perceived behavioral control (personal ability to take on the behavior) could have been affected by distance to health centers, or employment status. Employed men were less likely to participate in activities like antenatal care or spend quality time with the baby and mother due to work obligations which affected behavioral outcomes of the child.

The effect on the three constructs was reflected in the dimensions of male partner involvement. For example, if a father developed a negative attitude about the child due to gender, he was less likely to accompany or even offer financial support towards immunization of the baby or if the father was living in a domestically violent home, he was less likely to support the mother in home chores, may return home late to avoid the stress associated with violence and unable to provide emotional support to the family. These affected the health outcomes of both the baby and the mother.

1.9 Working definition of key terms.

1. "Male involvement" referred to fathers and other men in the community having knowledge of, facilitating, and actively participating in ensuring access to healthcare services for both women and children. A man was be considered involved if he was "*present, accessible, available, understanding, willing to learn and excited to provide emotional, physical and financial support to their household members*".
2. Maternal health care (MHC) comprised of services provided to women during pregnancy, childbirth, and the postnatal period.
3. Refugee referred to any person under forced international migration, including asylum seekers to find safety in another country.
4. Married meant father and mother living together.
5. Unmarried men meant father and mother not living together.
6. TPO Uganda was a non-profit making organization whose focus was to reinforce national and community systems and structures for the protection and promotion of rights to children and women.

2.0 LITERATURE REVIEW

2.1 Introduction

The unacceptably high maternal mortality rates in sub–Saharan Africa arising from preventable causes could have been reduced by timely access to quality medical support during pregnancy, labour, and the postnatal period. This could have been possible through advance preparation for childbirth during pregnancy which involved recognizing the importance of a skilled birth attendant, identifying the nearest facility, mobilizing financial resources for any medical expenses associated with childbirth, organizing transport to hospital in advance, identifying a birth companion and a potential blood donor, as well as knowing the signs of pregnancy complications (Faye, Wynter, Zeleke, and Fisher 2021). Unfortunately, patriarchal norms in sub–Saharan Africa countries tended to deny women the right to make decisions as well as unequal access to and control over resources such as money, transport, and time (Prerna et al, 2020). That placed male partners as key decision makers who played a pivotal role in a woman's ability to prepare for birth and respond to obstetric difficulties as well as responding to delays associated with seeking medical care, accessing hospitals, and appropriate care.

Additionally, fathers had an exceptional and distinctive role in their children's lives and children's long-term development was dependent upon the quality and amount of engagement they had with their fathers. Paternal involvement has evolved over time from stressing the father's role as a moral teacher and bread winner to modern perspectives that emphasize the importance of accessibility, actual engagement time spent with family as well as responsibility. Olajide et.al, (2020). On the contrary, Kroll, Carson, Redshaw, and Quigley (2016) noted that the father's quality

of parenting and not just frequency or routine care given, was linked to lower risk of child behavior problems. This result was coherent with the Longitudinal Study of Australian Children which reported that positive behavior in children was associated with the quality of parenting by the father and not contact time.

According to Olajide et al, (2020); accessibility was measured in terms of the fathers' presence or time that the father spent with the child and entire family regardless of the type or quality of the definite interactions. Engagement as reflected in direct interactions and activities between the father and the child such as care giving and play while responsibility was measured in terms of involvement with supervisory and parenting activities such as scheduling and following medical appointments and advice.

Plan International (2021) provided a wide-ranging and sustained behavioral change definition of male engagement that involved men taking an active position in protecting, backing up, and advocating for the wellbeing, health, and development of their household members. Male involvement went beyond just actions and decisions to include feelings, motivations, and relationships related to maternal health, childcare, and development. Involved men actively participate in protecting and promoting the health and wellbeing of their partners and children and this included providing emotional, financial, and physical support. Such men undertook joint obligation for unpaid care workload, child-rearing, and work beyond the home as well as supporting autonomous decision-making with their partners.

Despite the changes in the role and expectation of fathers in the lives of their family members, in sub-Saharan Africa, men's involvement in maternal health care was a new idea (Maluka and Kasege 2018). Policies favoring the recognition of the

importance of engaging men in reproductive and child health had not yielded the expected results as their involvement had continued to be low. This section of the study sought to establish ways in which male partners were involved in maternal and newborn health, benefits of having more involved fathers, facilitators, and barriers to their involvement through available literature.

2.2 Involvement of Male Partners in Maternal and Newborn health.

There was a broadly held belief that male partner involvement was important and crucial for maternal and child health (WHO, 2015; Yargawa and Leonardi-Bee 2015), but there was no common understanding of what it was, and the extent of involvement. This had given rise to varying perceptions of male partner roles ranging from instrumental to emotional support as explained by the social support theory. Although, it was believed that man was expected to care for and provide for his household members, the extent to which and way this was to be done varied. Motlagabo et al, (2018) noted that although some men consented that expressing love by helping with some physical tasks for their partner were necessary, men held unto their cultural norms and expectations of providing financial support as the primary duty in supporting their partners and believed that bonding with children was a woman's issue.

According to Mkandawire and Hendriks (2018), there were varying definitions of male engagement depending on the setting in which it was applied, similarly, different scholars used different indicators depending on circumstances. Prerna et al, (2020) defined male partner participation in the setting of maternal and child health as the active involvement of fathers and men in the community in the care of their partners and children through facilitating access to healthcare services for both women and

children. An involved man was one who was present, accessible, available, willing to learn about maternal and child health as well as having the willingness and ability to provide and facilitate appropriate healthcare.

Patriarchal communities placed men as key decision makers in family matters. They determine when and where women had access to skilled antenatal care (ANC), delivery/childbirth, and postnatal care, and childcare. These sometimes include deciding how their household members used health services, through provision of financial support or deciding whether a pregnant woman could travel to a referral facility. Unfortunately, gender structures had kept these key decision makers ignorant about danger signs in pregnancy and childbirth hence limiting their ability to make quick decisions during emergency situations. That limitation contributed to barriers that impede women from accessing timely healthcare services coupled with gender inequality, such as heavy household workload, limited decision-making power, and inaccessibility to health-related resources, hence affecting maternal and child survival (Furaha, Pembe, Mpembeni, Axemo and Darj 2016).

The perceived role of men of being a financial provider was explained by the Theory of Planned Behavior as one influenced by traditional and societal beliefs and/or norms and men's motivation to conform to those norms. Motlagabo et al, (2018) noted that some men in South Africa felt pressured to perform womanly duties on top of the financial support. There were reported disparities between the expectations of men and women in terms of paternal involvement. While men felt that they were actively involved, women believed men's involvement was lacking. For example, from a woman's perspective her husband's absence from antenatal care came from an unwillingness to participate, whereas men felt that they were

actively participating by providing transport. Additionally, Singh, Lample, and Earnest (2014) noted that while there was collective decision making regarding where to give birth, there was inadequate communication to enable men and women negotiate roles in pregnancy and delivery, but much had been left to cultural norms. Although, men were navigating within previously established gender roles, women seemed to want the men to move beyond those roles.

According to Redshaw and Henderson (2013), fathers were reported to be most involved after childbirth. Most fathers helped with infant care, specifically changing nappies, bathing, helping, or supporting feeding, helping when the baby cried, playing with the baby, and looking after the baby when the mother was out or at work. 96% of the fathers were involved in playing with the baby.

Additionally, men provided substantial practical, financial, and emotional support to women and children to overcome demand-side barricades to accessing health services in addition to encouraging adoption of health-promoting behaviours such as improved nutrition and hygiene practices.

Sakala, Kumwenda, Conserve, Ebenso, and Choko (2021) reported that men were involved in verbal instruction, support, and supervision but respondents often attached their comments on lack of knowledge surrounding newborns. Men were helpful in reminding other members to complete tasks such as traditional cord care, keeping the baby warm and breastfeeding rather than offering specific advice. Men also provided money for the needs of women and children and assumed the role of ultimate decision maker.

In a study conducted by Kaye, Kakaire, Nakimuli, Osinde, Mbalinda, and Kakande (2014), men who visited their admitted partners were ready to learn about their

expected roles before and during childbirth and they were excited to support their partners during this time. Similarly, fathers who participated in skin-to-skin contact activities for newborn children reported that the exercise was both satisfying and challenging (Shefaly and Lina 2019). One Swedish father reported the excitement derived from his fathering role despite it being a tough period: *"It's fun, completely amazing. It's so exciting, everything… Tough too, but more exciting than tough"*.

Men also reported that their role was to offer protection and love to their infants due to their vulnerability and helplessness. Shefaly and Lina (2019) reported that men were always available to protect their spouses and children. Other secondary tasks commonly assumed by men involved massaging their women during labour and naming of babies.

2.3 Importance of male involvement in maternal and newborn health

Research studies revealed significant benefits of male involvement in maternal and newborn health. Redshaw and Henderson (2013), reported that paternity leave was strongly associated with well-being of both the mother and baby within the first three months of life and that male partner support during pregnancy encouraged healthier maternal behavior, for example regarding cigarette smoking and alcohol consumption.

Women were also reported to place importance on their partner's presence and support during labour, which led to reduced anxiety, less perceived pain, greater satisfaction with the birth experience, lower rates of postnatal depression and enhanced outcomes in the child. Primiparous women were more likely to have a postnatal check with their doctor if spousal participation was adequate.

Father's involvement during pregnancy and after childbirth was also reported to affect infant feeding in terms of timeliness and duration. Women whose partners were more engaged during antenatal, and childbirth were more likely to breastfeed and for longer duration than their counterparts (Redshaw and Henderson 2013).

Tokhi et al, (2018), was in support of the above findings as she reported that interventions that engaged men in maternal and newborn health increased care-seeking, improved home care practices, improved antenatal care attendance, skilled birth attendance, facility birth, post-delivery care, birth and complications readiness and maternal nutrition and supported more unbiassed couple communication and decision-making for maternal and newborn health.

Fei-Wan and Xiao (2019) recommended a family-centered model of care during childbirth that involved both parents in the decision-making process as well as individualized birth plans that acknowledged both parents 'expectations and preferences in promotion of a positive childbirth experience.

While outlets of maternal health services had been reported to be growing, Sumitra, Bhuvan, and Khatri (2018) reported that men played the role of doorkeepers to healthcare in most developing countries. Being primary decision makers, men directly affected the utilization of resources and access to health care services and their actions in terms of abuse or disregard had a direct effect on both their partners and children.

Redshaw and Henderson (2013) related improved paternal engagement with first contact with health professionals (before 12 weeks gestation), increased number of antenatal checks, and regular attendance of antenatal classes, as well as prolonged breastfeeding. Comparable results were reported by Yargawa and Leonardi-Bee

(2015) that male partner involvement during pregnancy significantly decreased the likelihood of antenatal and post-delivery depression, decreased possibility of childbirth difficulties as well as enhanced utilization of maternal health services.

Yargawa and Leonardi-Bee (2015) associated male involvement during pregnancy and postnatal period with a reduced likelihood of childbirth complications specifically those related to heavy workload during pregnancy and insufficient rest. Additionally, it fostered adequate complication readiness and birth planning in form of recognizing and timely response to danger signs.

Lewis, Lee, and Simkhada (2015) noted that the husbands' presence at childbirth had positive long-term effects. For example, witnessing childbirth was cited as being educational for the husbands especially about the process, and this turned into more respect for women, and opting for smaller family sizes.

Although the childbirth process came along with some levels of stress and anxiety, low levels of paternal engagement were reported to be associated with extreme levels of maternal distress. The situation was worse among mothers in low-income countries where inaccessibility to resources has been reported to be major source of psychological distress. The situation worsened when it came to families of displaced persons for example refugees where loss of social support networks had been associated with maternal depressions (Lewis et al, 2015).

Plan International reported a feeling of satisfaction, adoption of health promoting behaviors and a reduction in alcohol consumption among men who were actively involved with the care and development of their children. Highly engaged men were less stressed due to increased emotional connection and ultimately more involved in their community. During care giving, men learnt new ways of interacting at

household level which were not related to power dynamics hence greater satisfaction with the marital relationship for both partners; reduced levels of stress within the family; greater equality in decision-making; and lower rates of domestic violence and physical punishment as well as reduced risk of sexual abuse of the children.

Male involvement was related to increased cognitive and socio-emotional development of children. Absentee fathers were related with poor educational, behavioral, and developmental outcomes in children with both direct effects on infant and child behavior and indirectly owing to partner relationship problems, lack of social support and exposure to increased levels of maternal stress hormones (Redshaw and Henderson 2013).

On the contrary, Montgomery, Ariane, and Kristine (2011) noted that male involvement had negative health or empowerment effects for a woman. It might change relationship and family dynamics in unforeseen and unreasonable ways, especially in antenatal care or female-controlled HIV/sexually transmitted infection prevention. For example, it was suspected to have adverse effects by strengthening regressive sex customs, disempowering women, and encouraging relationship disagreement or abuse. A similar campaign conducted in Zimbabwe revealed men who were involved in family planning were more likely to consider themselves the primary decision makers regarding family planning and parity. Similarly, Maluka and Kasege (2018) revealed that some Tanzanian pregnant women did not come back for the next visit when invited to come back for ANC services with their male partners.

Further to that, Mkandawire and Hendriks (2018) reported negative consequences of male partner engagement in maternal and nutrition programs in Malawi for example

discrimination against women, marginalization of married women and reinforcing men's decision-making roles.

Unfortunately, promotion of maternal and child health was largely perceived as women's role and men did not feel that they were responsible (Kabanga et al, 2019).

2.4 Perceived barriers and facilitators of male involvement in maternal and newborn health.

Planalp and Braungart-Rieker (2015) reported that fathers who were less happy in their marriage withdrew from their role as a parent. It was further noted that irrespective of a child's temperament, fathers exhibited a higher quality of co-parenting when marital quality was higher. Similarly, Shefaly and Lina (2019) noted that father-infant relationship was heavily influenced by spousal relationships. Families with health spousal relationships, men were reported to be more involved compared to those experiencing unhealthy relationships. Additionally, women with unhealthy spousal relationships commonly reported feelings of embarrassment having their husbands present during childbirth and such women were also found to be reluctant to share details of pregnancy and childbirth with their husbands as reported by Galle, Cossa, Griffin, Osman, Roelens, and Degomme (2019). Paradoxically, women with health spousal relationships felt safer sharing their feelings around pregnancy and childbirth and desired their husband's involvement despite childbirth being seen largely as a female domain. On the contrary, Schlecht et al, (2013) noted that conflict and post-conflict settings were characterized by exceptional relationships and informal marriage patterns resulting from fundamental shifts in economies, family relationships, and communication combined with structural changes encountered in settlements. It was noted that poverty, splintering

of family, and disruption in education aggravated by conflict greatly affected the views, perceptions, and behaviors of youth around relationships and marriage.

Fatherhood was shaped and influenced by socio-cultural contexts across geographical regions. Different communities and social norms define male involvement differently for example in rural South Africa, men engaged in ANC, housework and care of the baby were stigmatized as having been given a love potion (bewitched) or being mentally unfit (Motlagabo et al, 2018). Whereas supportive men were considered as "good" men in Southern Mozambique, that support was not expressed by doing "female tasks", and most of them were afraid of embarrassment accompanying their wives for ANC. During Galle's study, respondents did not like a sharp distinction of gendered roles but felt pressured by social norms to respond to traditional masculinities. Men were afraid that people would laugh at them or think their wife "bewitched" them if they escorted her for ANC and some older men supposed that it was not appropriate to enter inside the antenatal room (Galle et al, 2019).

Economic consequence was cited as a key consideration before men made decisions to be involved in maternal and newborn health issues for example 'working-class' men were less likely to take time off to escort their partners for clinic appointments, be present during child birth, or support postnatally, compared to 'middle-class' couples that tended to be better prepared for the transition to parenthood, better informed and supported more as reported by Redshaw and Henderson (2013). Shefaly and Lina (2019) also noted that balancing the role of a bread winner and being an involved father was reported as a big challenge to many fathers. This was because of the prolonged waiting time during ANC visits which was seen as a loss of income to many men coupled with limited availability related to income obligations, such as

working at a distant location from home or not being able to get time off from work (Kabanga et al, 2019). Additionally, that support was associated with both direct (out of pocket costs like transport) and indirect costs (opportunity cost of not being at work) Sakala et al, (2021). Work commitments were found to be a common hindrance to fathers' involvement across regions as men were expected to spent long hours at work. This coupled with informal self-employment and/or odd jobs with daily small incomes of often less than US$5 a day and failure to acquire permission from work for employed fathers. On the contrary, majority of the male partners in humanitarian settings were not employed and therefore spend most of their time with their family members or within the community.

On the other hand, the high level of unemployment hence financial inaccessibility was cited as a factor contributing to low male involvement in maternal and child health care according to Panyin, Kwame, and Tuoyire (2017). Since childbirth was a costly venture, men who were struggling financially tend to isolate themselves from such expenses as a way of protecting their identity. This was because failure to meet the gendered role of men as a sole provider tended to affect men esteem and image in the society.

Tokhi et al, (2018), the gendered role of being a sole provider for the family tended to engage men and therefore their attention and engagement in family and reproductive health was limited. This partly explained why women were targeted in most health education and awareness programs and ultimately, the justification behind men being unable to make informed decisions during urgent situations.

Kabanga et al, (2019) reported ill treatment of male partners by healthcare professionals. A similar case was reported in Singapore by Shefaly and Lina (2019)

where fathers were omitted during hospital stays and treated as ‘practical guys’ and ‘bystanders’ because they were not socially expected to be involved. The situation was worsened by poor policy implementation in Uganda coupled with overwhelmed healthcare system which quenched the desire for initiatives that invited more clients to health facilities (Galle et al, 2019). This partly explains why many Africa men were unable to make informed choices in such matters because for long they were excluded from reproductive, maternal and child health services and education (Amanual, 2018). The unprecedented mass influx of refugees in Uganda between 2016-2018 put extra pressure on the country’s constrained healthcare system. While as refugees share social services with the local host communities, it was noted that refugee hosting districts were among the least developed in the country. With the support of implementing partners, health service provision had greatly improved for both refugees and refugee hosting communities as reported in the health sector integrated refugee response plan 2019-2024.

Stigma associated with HIV testing and discloser during antenatal clinics was seen as a hindrance in Rwanda by Kabanga et al, (2019). Men perceived antenatal care visits as being synonymous with HIV testing. Men who suspected or knew that they were HIV positive and were not ready to have their status disclosed to their spouses disguising in protecting their fragile partners from emotional breakdown were less willing to participate in antenatal checkups. According to Kabanga et al (2019), men’s involvement was restricted and limited to HIV testing alone. Once HIV testing was finalized, men were not permitted to participate in the actual health consultation which provoked low confidence in the value of male involvement during ANC check-ups.

On the other hand, Sakala et al, (2021) noted that HIV negative results cemented relationships among couples which suggested that only a positive HIV result was feared and not necessarily the testing.

The contribution and effect of male involvement on health outcomes for women and children was correlated with their knowledge, education, opinions, and behaviours (Mkandawire and Hendriks 2018). Scarcity of knowledge regarding complications and danger signs in pregnancy and childbirth has created a barrier to their involvement. This was particularly detrimental since most African societies were patriarchal in nature where men manage household resources and made important decisions that affected maternal and child health. Diema, Japiong, and Dodam (2019) noted that three quarters of men who had knowledge on the severity of danger signs associated with childbirth promptly sought care in a health facility. On the contrary, a third of those men sought traditional healers for support. That implied that increased in knowledge of obstetric danger signs improved men's response maternal and child healthcare.

Additionally, Kabanga et al, (2019) emphasized lack of clarity of the role and responsibility of fathers during pregnancy and newborn care as a hindrance to male involvement. Educational curriculum experts reported that the training syllabus for Maternal and Child Health (MCH) nurses focused on women and children, with no definite attention paid to the role of men or their unique health needs such as inguinal hernia and prostate problems (Galle et al, 2019). Although attitude was cited as another factor affecting men's involvement, whereby positive attitudes and willingness fostered involvement, Mari (2014) noted that positive attitude alone did not translate in change in behavior.

Fathers' beliefs about their role and relationships (father vs. husband vs. bread winner) directed behaviors around father-infant interactions. For example, if a father believed that his sense of self was influenced by how well he addressed the responsibility of a father, then his engagement with his children was higher. On the contrary, if a father's sense of self was determined by increased time and effort in the workplace, father involvement would be lower. Planalp and Braungart-Rieker (2015).

According to Planalp and Braungart-Rieker (2015), there was an inverse relationship between the level of involvement of the mother and that of the father in other words mother involvement predicted father's involvement, but the reverse was not true. Fathers compensated for a less involved mother or did not engage when the mother was highly involved, leading to a negative association between mother and father involvement.

Socio-demographic factors like education level of the father and level of relationship affected involvement according to Planalp and Braungart-Rieker (2015). It was noted that highly educated fathers provided higher levels of verbal stimulation and biological fathers were reported to be more involved than non-biological.

Similarly, Panyin et al, (2017) noted that the education level of the woman was an influencing factor to men's involvement; whereby high levels of education among pregnant women were linked to high levels of male partner involvement. Implying that uneducated women were less likely to discuss maternal health issues with their spouses than their more educated counterparts.

Redshaw and Henderson (2013) reported psychological stress associated with childbirth as a hindrance to male participation. Some men especially the first-time

fathers expressed fears and a sense of unworthy seeing their partners in pain that they could not help, failing to respond, fear that their partner would have a prolonged or complicated labor, that she or the child would die or that the child would be born handicapped. Prouhet, Gregory, Russell, and Yaeger (2018) reported that fathers of preterm babies were often stressed, isolated and overwhelmed. It was also noted that the Neonatal Intensive care Unit (NICU) environment jeopardized the process of early attachment between the father and infant.

Although men were reported to have expressed a yearning to be more involved in the life of their family members, there existed many challenges and difficulties in fulfilling the ideal type of fathering role. Shefaly and Lina (2019) reported that, men in the United Kingdom were becoming more involved in family life and taking more responsibility in childcare duties. However, they remarked that they were being 'pressed' between playing the role of an involved father and a breadwinner. American fathers were knowledgeable of the ideal types of recommended fatherhood, but they were held back by culture. On the other hand, Asian mothers provided more physical and emotional care to their children compared to the fathers.

A study on male involvement among displaced communities revealed unique interests and worries that prevented fathers from being fully involved with their families. For example, feelings of helplessness due to underemployment and inability to provide for their families. Perceived segregation and discrimination from the community also affected the fathers' well-being hence compromising their levels of involvement. (Sascha, 2020)

Complicated relations associated with polygamy and extramarital relationships were cited as potential hindrances to male involvement by Galle et al, (2019). Having more

than one wife made it hard for a man to be equally and actively involved in the lives of each woman and child raising. In addition to poverty aggravated by insecurity, polygamy characterizes 40% of the marriages in South Sudan.

Galle et al, (2019) also noted parental commitment or willingness to accept responsibility as an important factor that influenced men's decision to be involved. This was common during first pregnancies especially among adolescent mothers and those who were not officially married, men tended to attempt to escape and sometimes deny responsibility for fear of being apprehended. Similarly, married men in informal relationships or cohabiting (not officially married) tended to be less involved where the pregnancy was unplanned for, whereas when the pregnancy was planned, men were proud, prepared, and willing to engage. Mothers with planned pregnancies were also more likely to have a partner who gained access to information about pregnancy and birth and participated in decision-making concerning pregnancy and labour. Redshaw and Henderson (2013) noted that partners of first-time mothers with planned pregnancies were slightly more likely to have taken paternity leave and were more likely to have done so for longer. It was also noted that paternal engagement was higher in women with prior complicated deliveries for example forceps delivery, induced labor, and caesarean births than they fellow counterparts. The experience gotten by engaged spouses of such women possibly prompted earlier interventions in succeeding pregnancies. Although men who abandon pregnant women tended to return a few months after childbirth, many came back when the most difficulty and risky period had passed.

Socio cultural gendered divisions of labour placed both men and women in particular physical spaces. While industrial revolution placed many women in the workspace,

patriarchal societies limited ways in which men engage in pregnancy, birth, and child rearing to providing financial support and women retained the responsibility of completing household duties and taking care of family members. Societies where social norms, beliefs and values weaken women's rights, men had social and economic supremacy over their partners. They decided whether women should have access to economic resources and healthcare service. Men had been largely involved in secondary and supportive activities like provision. This had limited opportunities for them to engage in hands-on newborn care and those who did were often stigmatized or discouraged (Sakala et al, 2021).

Mari (2014) reported that certain physical spaces or spheres of influence under maternal and newborn health were completely under female influence and control with men playing a very limited or no role at all for example the delivery room was restricted to only women during the most active parts of labour. Additionally, men were not supported to perform care tasks like breastfeeding, cord care and bathing which limited physical contact with the newborn. It was noted that the dominating influence of mothers-in-law during late pregnancy and shortly after childbirth reinforced closed spaces to male influence. The mothers-in-law discouraged paternal involvement in decision making processes by disregarding their contributions on the pretext that they were not experienced and had little knowledge.

Lowe (2017) had noted that feminine association of pregnancy and childbirth as well as negative feelings attached to male involvement were rooted in local beliefs and cultural norms. For example, apart from predicting birth difficulties if the husband was present during childbirth, no physical contact was expected three to seven days after childbirth (Lewis et al, 2015). This was supported by Shefaly and

Lina (2019) who reported that American fathers acknowledged the ideal types of fatherhood, but they were still hindered by culture. Sakala et al, (2021) observed that while men were fully responsible for the pregnancy, childbirth and newborn care was a woman's space with men considered as trespassers. Tobijo et al, (2021) noted that social sensitivity towards women after childbirth discouraged fathers from sleeping in the same room with a breastfeeding mother for two years. In South Sudan, the culture of male dominance forced communities to view that domestic work related to childcare as purely feminine.

Furthermore, the traditional tendency of predominantly viewing maternal health as a purely feminine issue had contributed to a narrow focus of prioritizing women, particularly mothers in intervention efforts to reduce maternal and child mortality. This had contributed to men being sidelined and excluded from reproductive health and maternal and child healthcare matters, thereby reinforcing the erroneous notion that pregnancy and the processes leading to childbirth were the preserve of women (Panyin et. al, 2017).

Additionally, Galle et al, (2019) reported that men supporting their wives by showing interest in their health or sharing household tasks were under looked and seen as weak or as a manifestation of HIV seropositivity.

Rural to urban migration had increased exposure to foreign ideologies as well as multi-cultural differences hence increasing willingness among men to learn and be involved in maternal and newborn health (Lewis et al, 2015). Additionally, in her study, Shefaly and Lina (2019) reported that men were willing to be oriented on their family roles and those who participated in skin-to-skin contact for newborn children

derived a lot of satisfaction. Unfortunately, ANC visits had plenty of activities for mothers, and little male partner-centered focus as noted by Sakala et al, (2021).

Shefaly and Lina (2019) also noted breastfeeding as a limitation to father-infant interactions during the first months of life as babies got tied up to their mothers. That made fathers feel 'insignificant' and 'distant' from their infants and limited in what they could do.

Epidemics like COVID 19 resulted into restrictions that hindered several partners from attending appointments, being part of maternity care discussions, hence limited knowledge of the maternity services. The isolation and exclusion were reported as being psychologically detrimental and uncalled for as men felt marginalized and overlooked during maternity care experience. Vidanka et al, (2021) noted that the few partners who were allowed in the labor ward during the pandemic suffered pressure since they were the only source of support. On the other hand, it helped the mothers have ample time to rest which was a recommendation for an effective healing process.

It was observed that in most studies, data was neither collected directly from men nor were the benefits of male involvement for the father himself explored or assessed which was a likely hindrance to their active participation. People were more likely to participate in interventions for which there is mutual benefit, unfortunately, father involvement had been used as an instrumental approach to improve only maternal and child health (Galle et al, 2019). To actively engage men, it was important to highlight the perceived benefits of involving fathers e.g., improved access to healthcare services (Cairo conference 1995). Emphasizing the

personal benefits of father involvement as well as investing in his specific needs during the transition to parenthood could be explored as an intervention strategy.

Chepkemboi, Kombe and Makokha (2021) noted that motivations were an efficient way of increasing male involvement in antenatal care nevertheless this was not sustainable and had negative effects. An increase in male attendance was achieved at the expense of some women's health as village chiefs hindered health providers from attending to women who reported minus their husbands.

During labor, women desired a compassionate and trustworthy companion present during labour and childbirth, and this created a positive birth experience. Despite this, women had mixed viewpoints about having a spouse present (Meghan, Berger, Heather, and Tunçalp 2019). Meghan et al, (2019) further noted that men who had an opportunity to be labour companions had a personal satisfaction, felt that their presence and contribution made a positive impact on both themselves and on their relationship with their partner and baby, but also reported not being integrated into the care team or actively involved in decision-making.

Tobijo et al, (2021) reported more notable barriers to male involvement and these included environmental characteristics, alcohol abuse, playing games, distance from home and peer influences. It was noted that exposure and knowledge increased male partner involvement. The study therefore assessed the effect of living in a humanitarian setting on male partner involvement.

Interventions to support involvement of men in maternal and child health had been largely donor funded and many had not yielded the expected results due to unsustainable financial systems, challenges in technology adoption, limited stakeholder and target groups involvement, and genuine acceptance at community

level. Additionally, some male involvement efforts were implemented by institutions and not engrained within communities, Prerna et al, (2020).

Since fathers were central in decision making, their involvement in pregnancy related issues should be greatly enhanced by overcoming traditions that associate it predominantly as feminine since it necessitates a number of important decisions to make for example, scheduling and attending medical appointments, selecting a delivery method, and deciding on infant feeding (Singh et al, 2014).

Conclusion

According to Sumit et al, (2016) cultural practices shaped fathering behaviors and perceptions, and multiple factors influenced the socially defined gendered roles of men being breadwinner and women caregiver. Hence care should be taken in designing and implementing male involvement interventions to mitigate potential harmful effects on couple relationships (Tokhi et al, 2018). Olajide et al, (2020) recommended that these should follow acceptable levels of paternal involvement differed across cultural backgrounds hence appreciating social customs surrounding sexuality and reproduction across cultural groups, was important in developing and implementing locally appropriate/acceptable public health responses.

A range of societal, historical, and political processes, gender inequalities and the patriarchal nature of societies entrenched among South Sudanese positioned women at a disadvantaged side in all realms of life (Kok, Sumit, Rial, Matere, Dieleman and Broerse 2016). Whereas studies had been conducted on factors affecting male partner involvement, there was need to appreciate that fundamental shifts in economies, disruptions in family relationships and a breakdown of community structures which had greatly affected the views, perceptions, and behaviors of youth

in humanitarian settings around relationships and marriage responsibilities (Schlecht et al, 2013).

Loss of valued social roles was cited by Goodkind, et al, (2013) as having negatively impacted health and well-being of refugees. Appreciating cultural knowledge and experience among refugees enabled maintenance of cultural connections and identity which was important in reconstructing valued social roles. Culturally appropriate community-based interventions built upon refugees' cultural strengths, re-established important valued social roles. Whereas all these factors affected male partner involvement among persons in humanitarian settings, no studies had been conducted to ascertain the status, facilitators, or barriers to male partner involvement in maternal and child health. In order to develop tailor-made and contextual programs and interventions, there was a need to understand the context of a humanitarian setting. This study established the status of male partner involvement among families in a humanitarian setting, ascertained factors that facilitate and barriers that hindered men from actively being involved in maternal and newborn health.

3.0 METHODOLOGY

Introduction

This section of the report provides a detailed description of how the study was conducted. It presents principles which were followed, actions taken, and practices embraced during the study including the rationale for the choices made. Presented here are study design, study population including size and sampling techniques, tools and procedures used in data collection, strategies for data processing and analysis, strategies applied to improve validity and reliability, ethical considerations made and faced during the study.

3.1 Study design

This was a descriptive cross-sectional community-based survey, that employed both qualitative and quantitative data collection methods. Mixed design allowed comparison of different variables at the same time and permitted triangulation and validation of data. The design also enabled the researcher to complete the study within the available time since data was collected once.

3.2 Area and population of study

The study was conducted in Imvepi refugee camp located in Odupi sub-county, Terego District, Northern Uganda. Imvepi refugee camp was opened in February 2017 and by 2021, it hosted 69,198 refugees (UNHCR 2021). Imvepi was particularly selected over other settlement areas because of its population composition (by the time of the study, 98 percent of the refugees in Imvepi were South Sudanese). Uptake and continuity of low-cost lifesaving interventions like early initiation, exclusive breastfeeding for the first six months and sustainability up to 2 years, as well as

contraceptive use reduced childhood illnesses by half. Although it was reported that adequate male partner involvement enhanced uptake of these interventions, according to Tobijo et al, 2021, contraceptive use among South Sudanese was estimated at 5% and exclusive breastfeeding rate among refugees in Uganda had dropped from 90.7% to 62.3% (UBOS 2020).

Whereas the study population comprised of South Sudanese refugees in Imvepi refugee settlement, to avoid recall bias, the study samples were taken from mothers and fathers with children 2 years and below.

3.3 Sampling technique and sample size determination

To enable generalization of the results, 2 zones were purposively selected to represent urban (surrounding service centers or within 3 kms to hospitals, schools, distribution centers etc.) and rural populations (4 kms and above away from service centers).

Using stratified random sampling, 3 villages were selected from each zone and a list of households with children 2 years and below developed with the help of zone leaders (Refugee Welfare Councils). Households (unit of analysis) were selected using simple random sampling technique.

A minimum sample size of 385 was determined using Willian B. Cochran's formula ($n=Z^2(up)/e^2$) since the population of eligible participants was infinite. Other considerations made included level of precision/margin of error (0.05), a standard error associated with a 95% confidence interval of 1.96 (z) and variability +/-0.5. To increase precision and cater for non-response and poorly filled or incomplete responses, the minimum sample size was increased by 10%, this gave rise to a total sample of 424. For a good representation of the study population, sampled

participants were in a ratio of 21:17 (women to men) as recorded by Uganda - Refugee Statistics July 2021 - Imvepi.

Table 1: Summary of Participants for quantitative data

Category	**Sampling technique**	**Sample size (frequency n=424)**	**Percentage**	**Justification**
Mothers	Simple random	234	55%	The ratio of women to men (adult refugees) in Imvepi is 21:17 (Uganda - Refugee Statistics July 2021 - Imvepi)
Fathers	Simple random	190	45%	
Total		**424**		

Attempt was made to ensure that qualitative data was collected to saturation point i.e., more probing and paraphrasing of questions did not result in additional responses. Following recommendation by Hennink and Kaiser (2022) on saturation point, a total of eight FGDs and three Key Informant Interviews were conducted. Villages with the highest proportion of the sampling frame had more representatives in FGDs and this aimed at ensuring that the sampled population was a true representation of the study population.

The sampled population was stratified according to age (e.g., minors (below 18 years), and adults (18 years and above) and marital status. The categorization aimed at providing insight into the effect fundamental shifts in economies, disruptions in family relationships and a breakdown of community structures on views, perceptions, and behaviors around relationships and marriage among people in humanitarian settings as reported by Schlecht et al, (2013). The stratification also enabled comparison of male involvement between married (husband and wife living together) and unmarried men (husband not living together with the wife).

To encourage free and open discussions, women were interviewed separately from men during Focus Group Discussions. Similarly married women and those living separately from their husbands had separate FGDs.

Key informant interviews comprised of zone leaders (RWCs) and senior citizens as well as health workers attending to women and children at the two health facilities in Imvepi refugee camp. Within the villages, key informants were identified by village leaders.

Table 2: Summary of study participants for qualitative data

Activity	**Location**	**Frequency**	**Expected participants**	**Selection criteria**
Key Informant Interviews (KIIs)	Health centers	2	Health workers	Purposive
	Zones	2	• Zonal leaders • Village leaders • Senior citizens/elderly • VHTs	Purposive
FGDs	Villages	2	• Married mothers	• Stratified random
		2	• Single mothers	• Stratified random
		2	• Married Fathers	• Stratified random
		2	• Fathers not living with mothers	• Stratified random

Eligibility criteria

1. Sampling frame/target population: South Sudanese refugees in Imvepi refugee camp.
2. Source population: parents with children aged 2 years and below.
3. Study population: a part of the sampled population who willingly provided consent and/or assent to participate in the study. Adolescents with no caregivers, consent was obtained from village leaders.

Exclusion criteria

- Non biological parents of children 2 years and below.
- Refugees whose country of origin was not South Sudan
- Residing in zones where less than 50% of the households were South Sudanese.

3.4 Study Variables and indicators.

Dependent variable

Male partner involvement (MPI) was defined as a man being "present, accessible, available, understanding, willing to learn and enthusiastic to support women and children emotionally, physically and financially".

Indicators of male partner involvement took recommendations by Olajide et.al, (2020) namely Accessibility, Engagement, and Responsibility. Accessibility was measured in terms of the fathers' presence and availability to the child and entire family regardless of the category or quality of actual interactions. Engagement was measured in terms of direct interactions and activities between the father and the child such as care giving and playing while responsibility was measured in terms of engagement with supervisory and parenting roles such as scheduling and following through medical appointments.

Independent variables

Among the factors that affected male partner involvement, the study focused on; distance to service centers, marital status, education status of partners, and employment status of male caregiver.

Distance to service centers was categorized into rural (4 kms and above from service centers) and urban (3kms and below from service centers); in terms of marital status participants were either cohabiting, living separately, legally/culturally married, or

minor (for mothers below18 years of age). Education status was divided into never enrolled in school, did not complete primary, completed primary, completed secondary and tertiary.

3.4 Data collection

Data collection was conducted by a team of 4 well-trained research assistants (2 per zone), knowledgeable of the local languages, using Computer Assisted Personal Interviewing (CAPI) technology accessed on smart phones, both online and offline. A Kobo collect mobile application was chosen because it supported a full data collection cycle from designing data collection forms, data collection including auto recording of responses from FGDs and key informant interviews. The application also improved data accuracy since simple analyses or data validation enabled quick feedback to research assistants. Research assistants underwent 2 sessions of training (virtual and physical). To minimize selection bias, data assistants did not collect data from their respective zones of residence. Data collectors residing in zone 2 interviewed participants from zone 3 and vice versa.

Voluntary participation was emphasized, and all participants received detailed information about the study and their willingness was sought using a consent form. To enhance confidentiality, interviews were conducted in respondents' residential houses and whenever a sampled respondent was not present during the first home visit, two re-visits were made.

Quantitative data on availability and engagement was collected from 422 participants using closed ended questions. Additionally, the interview schedule presented open-ended questions where respondents freely expressed themselves and discussed at length the themes as asked.

To collect qualitative data, participants responded to a set of open-ended questions. Deeper assessment of the level of engagement and responsibility as well as facilitators and barriers to male partner involvement, the researcher conducted eight FGDs and 3 key informant interviews. Each FGD was to comprise of a maximum of 12 participants while KIIs comprised of 8 participants maximum. FGDs comprised of mothers and fathers whereas one of the KIIs comprised of health workers who attend to mothers and children at the two health services within Imvepi and the other two KIIs comprised of community leaders and senior citizens. FGDs enabled collection of gender-oriented views and beliefs regarding male partner involvement since mothers were interviewed separately from fathers.

Discussions held during the 8 FGDs and 2 KIIs were audio-recorded in kobo toolbox in addition to documentation of discussion notes. A KII with health workers was not audio recorded because participants did not consent to that effect. Discussion notes were documented during the interview.

Pre-testing of data collection tools

To check for ambiguities and comprehensiveness of the questionnaire and interview guide as well as the ability of research assistants to utilize the technology, the data collection tools were pre-tested on 31 participants selected from zone one (1). Pre-test results were used in reviewing the questionnaire and interview guide and final copies developed which were used in data collection. Zone 1 was selected for pre-testing because it was not among the purposively selected zones for this study and refugees in this zone were experiencing the same challenges and benefits as those in the other zones.

Qualities of data assistants were,

- Knowledgeable of the most common local languages (Bari, Kakwa and local Arabic).
- Analytical – ability to test the reliability (consistency) and validity (accuracy) of the information that the interviewee offers.
- Gentle – tolerant, sensitive, and patient when receiving confrontational, sensitive, and unconventional sentiments.
- Guiding – directing the course of the interview to prevent digressions from the subject.
- Interpretation – being able to interpret what the interviewee had said without having to misinterpret the information.
- Ability to use the data collection application.
- Probing: ability to solicit more information from the interviewees.

3.4 Data collection instruments and equipment

The study collected quantitative data using semi-structured questionnaires and qualitative data using interview schedules and during one-on-one interview, Key Informant interviews (KIIs) and Focus Group Discussions (FGDs). Interview schedules were preferred to ensure completeness of the data, allow for probing and hence collection of more data in addition to reducing the hassle of having the questions translated in different local languages.

Data collection instruments were accessed on a mobile application like an android mobile device both offline and online on a kobo collect account. Synchronization of the system to update data entered offline required internet accessibility. For safety

and confidentiality, data was stored on google sheets under the researchers specified goggle account.

3.5 Strategy for data processing and analysis

To analyze qualitative data, it was downloaded from the google drive account and cleaned/validated. During cleaning, incomplete, and unusable data was removed. Audio data was transcribed verbatim in a local language and then translated into English language by the 4 data trained assistants. During translation, all the 4 data assistants listened to one audio recording and each assistant transcribed it verbatim. The 4 transcribed documents were reviewed and merged into one by the data assistants. Each data assistant appended his/her signature on the merged transcribe as confirmation of his/her agreement that the written content was a fair representation of the audio recording.

For confidentiality, all data was coded. The researcher applied thematic analysis by reading and re-reading of the data to identify similar phrases, themes, opinions, and patterns within the text through word or idea repetition. Differing options and patterns were also captured. Coded data was organized into themes and sub-themes relating to education attainment, marital status, distance to service centers and context-specific factors that affected male involvement among refugees in a humanitarian setting were extracted and included in the results.

Common themes that addressed the research questions and generalizations representative of the study populations were studied in line with existing knowledge/literature and quantitative data obtained.

Generalizations were categorized into facilitators and barriers to male involvement as well as contextual and homegrown initiatives to support male involvement in

humanitarian settings have been presented in an objective way, with verbatim responses from study participants as evidence and to ensure that the analysis remains close to the study participants' point of view.

3.6 Validity and Reliability

Data collection instruments (interview schedules) were pre-tested, and results were used to improve the tool as well as assessing its ability to comprehensively collect data required to achieve the research objectives.

Accuracy was improved by pre-testing the interview schedules, training, and close supervision of research assistants. Routine data checks to ascertain completeness and consistence of completed forms as well as timely provision of feedback to research assistants during data collection, this ensured that collected data was usable.

Detailed reporting on the processes involved in data collection and analysis aimed at ensuring that results are dependable and replicable.

Audio recordings and verbatim transcribes enhanced reliability of the study results.

Only trained data collectors/assistants participated in the data collection process. The data assistants were tasked to apply probing and paraphrasing of respondents' responses for reliability.

3.7 Ethical considerations

- Respondents were assured of their safety, privacy, and confidentiality. All participants aged 18 years and above were given an opportunity to understand in detail the implications of their participation and requested to provide verbal consent as proof of their willingness to participate in the study. Effort was made to acquire consent from parents or caretakers all adolescents who

were involved in the study and where there was no caregiver, consent was sought from zone leaders. Upon being granted permission/consent by parents/caretakers, adolescents were also supported to fully understand the impact of their participation and requested to provide proof of their willingness to participate by providing a verbal assent. Full disclosure enabled study participants to make informed decisions/consent, but it also reflected the level of respect and autonomy during the study.

- Audio recording of participants' responses was done with permission from the participants.
- To ensure no harm to the participants and given the context of COVID-19 and Ebola outbreak, interviews were conducted in cognizant of the standard operating procedures (SOPs).
- Ethical clearance to conduct the study was sought from the UCU research ethics committee and from the Office of the Prime Minister through the Regional Program Director (RDO) and Chief Commandant - Imvepi Refugee Settlement.

3.8 Study constraints and limitations

The study focused on only biological parents; thus, findings are generalizable to that specific population.

The high poverty levels coupled with lack of income generating activities among persons in humanitarian settings had cultivated a dependency syndrome. Many people looked forward to relief aid which made adherence to a clear selection criterion hard. People anticipated that participation in the study would mean direct gain and therefore many flopped to be interviewed. To overcome this challenge, the

researcher involved zone leaders in the data collection process. Zone leaders were highly trusted people within the communities, but it also helped in curbing violence as some people would have made their way on the list of participants by force or harmed the data collectors for leaving them out.

4.0 DATA ANALYSIS, PRESENTATION, AND INTERPRETATION OF FINDINGS.

4.1 Data cleaning and verification

During the data collection process, the researcher kept reviewing submitted data for completeness, and consistency and feedback was provided to research assistants in a timely manner. The data collection tool was reviewed to improve data accuracy and completeness, specifically, some fields were made mandatory for example birth attendant, and marital status. With the help of summary reports generated by the data collection application tool (kobo), the researcher validated all submitted data; consequently, the following responses were not validated.

1. 1% of the responses (6) who had not consented to participate in the study.
2. 0.17% of the responses (1) was sampled outside the study population.
3. 1% (5) responses from minors (under 18 years) lacked consent from an adult/caregiver.

After the validation process, 410 responses were used during the study, yielding a response rate of 96.9% (with a non-response bias of 3.07%). This response rate (96.9%) was higher than the minimum acceptable rate of 60% for quantitative research studies according to Fincham, 2008. The high response rate was attributed to the study area, in humanitarian settings participants were close to one another, and the majority of the respondents had no jobs to keep them busy and engaged. Each validated interview was assigned a unique code for purposes of confidentiality. Data was then downloaded and exported into a data statistical package (SPSS) version 20.0 for analysis into frequencies and percentages.

4.2 Data Presentation

This chapter presents analysis and interpretation of results based on the data collected from participants. The data collection was premised on the study objectives shown in chapter one section 1.5.2, namely.

(1) To establish the level of male partner involvement in maternal and newborn health among families in selected zones in Imvepi refugee settlement.

(2) To identify facilitators/enablers of male partner involvement in maternal and newborn health among families in South Sudanese selected zones in Imvepi refugee settlement.

(3) To investigate barriers that hinder male partners from actively participating in maternal and newborn health among families in selected zones in Imvepi refugee settlement.

In the presentation of the findings, demographic characteristics of the respondents were presented first. Demographic characteristics were relevant in understanding variations that existed amongst the study population (Hammer, 2011). This covered Location (zone), Gender, Type of Marriage, Marital Status, Employment status of Male Partner, and educational status of Male Partner.

a) Characteristics of respondents

Table 3.1: Demographic Characteristics of the respondents

Variable	Category	Frequency n=410	Percentage
Zone	Zone 2	240	58.5
	Zone 3	170	41.5
	Total	**410**	**100.0**

Age	Minors	33	8.0
	Adults	377	92.0
	Total	**410**	**100.0**
Gender	Mothers	229	55.9
	Fathers	181	44.1
	Total	**410**	**100.0**
Type of Marriage	Monogamous	236	57.6
	Polygamous	151	36.8
	NA Minor	23	5.6
	Total	**410**	**100.0**
Employment status of Male Partner	Not Employed	298	72.7
	Partially employed	39	9.5
	Self-employed	70	17.1
	Fully employed	3	0.7
	Total	**410**	**100.0**
Marital Status	Cohabiting	135	32.9
	Legally Culturally Married	187	45.6
	Living Separately	88	21.5
	Total	**410**	**100.0**

Source; field data, 2023

4.2.1. Zone (Access to service centers)

In terms of access to service centers e.g., health facilities, schools etc. Zone 2 represented rural populations because all the sampled villages were located 4 kms away from the health center whereas zone 3 represented urban populations because sampled villages were around the health facility.

Effort was taken to ensure that a stratum with a high sample size had more participants selected. Zone 2 had a population of 7,404 households whereas zone 3 had 2,961 households (Uganda Refugee statistics June 2021-Imvepi). Therefore 58.5% of the participants were sampled from zone 2 and 41.5% from zone 3. According to

Tobijo et al, (2021) distance to health facilities was a notable barrier to male involvement.

4.2.2. Age of the mother

92% of the mothers were adults (18 years and above) and 8% were minors (below 18 years old). Jensen, 2019 had noted that humanitarian settings were characterized with sexual abusive acts including transactional sex, forced prostitution, gang rape etc. Under such circumstances, fathers are not involved in maternal and child health.

4.2.3 Study Participants by Gender

44.1% (181) of the respondents were fathers and 55.9% (229) were mothers. The proportion of respondents by gender was representative of the study population in Imvepi where the ratio of women to men was 21:17 according to Uganda - Refugee Statistics July 2021 – Imvepi. Both mothers and fathers participated in the study as a means of reducing information bias but also to ensure that the sampled population was representative of the study population.

4.2.4 Study Participants by type of marriage

According to type of marriage, 57.6% (236) of the respondents were living in a monogamous marriage, 36.8% (151) were from polygamous marriages and 5.6% (23) were minors (below 18 years). Minors were not interviewed on type of marriage according to the Ugandan constitution, they were not expected to be married. Complicated relationships associated with polygamy and extramarital relationships were cited as potential hindrances to male involvement by Galle et al, (2019). Such relationships made it hard for the father to be equally and actively involved in the lives of each woman and child raising. Additionally, polygamy aggravated poverty which was another hinderance to male participation.

4.2.5 Employment status of Male Partner

In terms of employment status of male partners; 0.7% (3) were fully employed, 72.7% (298) were not employed, 9.5% were partially employed, and 17.1% were self-employed. Redshaw and Henderson (2013) noted that men involved in full time employment were less likely to take off time or acquire permission from work to participate in maternal and child health. Additionally, Sakala et al, (2021) noted that self-employed fathers especially those with odd jobs with daily small incomes of often less than US$5 a day prioritized work for the sake of family wellbeing.

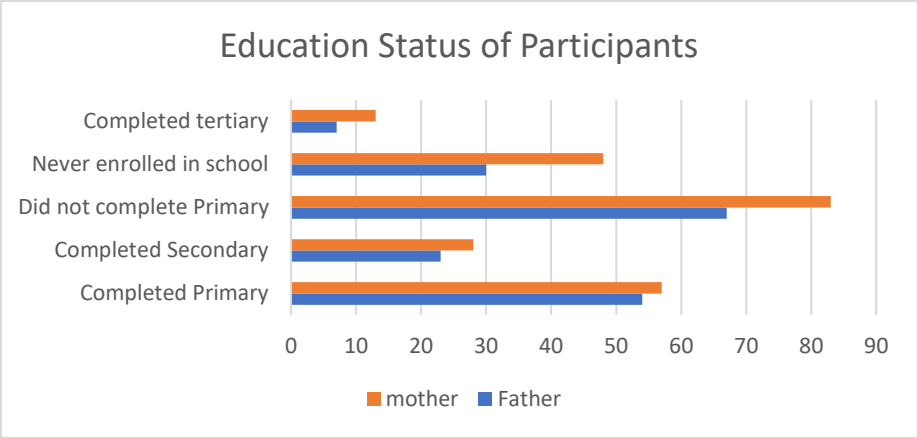
On the other hand, Panyin, Kwame, and Tuoyire (2017) reported that the high level of unemployment hence financial inaccessibility hindered male involvement in maternal and child health.

4.2.7: Marital status of participants

135 of the sampled participants were cohabiting, 187 were legally/culturally married and 88 were living separately. Galle et al, (2019) reported that married men in informal relationships or cohabiting (not officially married) tended to be less involved where the pregnancy was unplanned for, whereas when the pregnancy was planned, men were proud, prepared, and willing to engage. Mothers with planned pregnancies were also more likely to have a spouse who obtained information about pregnancy and childbirth and participated in decision-making in pregnancy and during labour.

4.2.8: Education status of study participants

Fig 2 – Education status



Source; field data, 2023

Of the 181 fathers who participated in the study, 54 completed primary, 23 completed secondary, 67 did not complete primary, 30 were never enrolled in school and 7 completed tertiary education.

57 mothers completed primary, 28 completed secondary, 83 did not completed primary education, 48 were never enrolled in school and 13 mothers had completed tertiary education. 54% of the fathers never completed primary education compared to 58% of the mothers. Planalp and Braungart-Rieker (2015) noted that highly educated fathers provided higher levels of verbal stimulation. Similarly, Panyin et al, (2017) recorded that education level of pregnant women determined male involvement for example uneducated women were less likely to share and involve their men in decisions related to maternal health than their more educated counterparts.

b) Data on availability

Table 3.2: Data on availability of male caregivers

Variable	Category	Yes	No	Total
Present during the pregnancy test	Zone 2	62	178	240
	Zone 3	53	117	170
	Total	**115**	**295**	**410**
		Father	**Other**	**Total**
Childbirth attendant	Zone 2	45	195	240
	Zone 3	2	168	170
	Total	**47**	**363**	**410**
		Zone 2	**Zone 3**	**Total**
Antenatal visits made	None	198	108	**306** (74.6%)
	1-2	39	53	**92** (22.4%)
	3-4	03	08	**11** (2.7%)
	More than 4	00	01	**01** (0.2%)
	Total	**240**	**170**	**410** (100%)
	Category	**Frequency**	**Percentage**	**Cumulative**
Father spending more time with family	Yes	194	47.3	47.3
	No	216	52.7	100.0
	Total	**410**	**100.0**	
The average time father spends with family per week.	More than 15 hours	62	15.1	15.1
	10-14 hours	79	19.3	34.4
	5-9 hours	118	28.8	63.2
	Less than 4 hours	128	31.2	94.4
	Never	23	5.6	100.0
	Total	**410**	**100.0**	

Source; field data, 2023

4.2.9: Pregnancy test attendance

Participants were interviewed on whether male caregivers were present during confirmation of a pregnancy, 115 male partners were present, 62 (25.8%) from zone

2 (rural) and 53 (31.2%) from zone 3 (urban). Galle et al, (2019) reported that mothers with planned pregnancies were more likely to have a partner who was willing to access information concerning pregnancy and childbirth and participated in decision-making concerning pregnancy and during labour. From the above statistics, it can therefore be deduced that accessibility to health facilities was a major contribution to male participation right from pregnancy testing.

4.2.10: Birth attendant

Participants were interviewed on whether fathers were birth attendants or present in hospital during the birth of their youngest child. 71 (17.3%) male caregivers were present in the health facility during the birth of their youngest child and 47 of these were birth attendants. Mari (2014) reported that certain physical spaces or realms of influence under maternal and newborn health were fully under female control. Here men played a limited or no role at all for example the delivery room was restricted to only women during the most active parts of labour.

Furthermore, Lewis et al, 2015, noted that birthing difficulties were culturally predicted if the husband was present during childbirth and no physical contact was expected three to seven days after childbirth. Coupled with reported cases of mistreatment of fathers by health workers, many had for long detached themselves from issues around childbirth. Contrary to the works of Mari and Lewis et al., men in humanitarian settings seemed to be interested and attached a little more importance to the childbirth process compared to their counterparts.

4.2.11 Antenatal clinic attendance

Participants were interviewed on whether male caregivers attended antenatal clinic along with the spouses during pregnancy, 74.6% did not attend, 22.4% attended at

least one antenatal clinic, 2.7% attended at least twice and 0.2% attended at least 4 antenatal clinics. According to Kabanga et al, (2019) stigma associated with HIV testing and discloser during antenatal clinics was a hindrance to male involvement as men perceived antenatal care visits as being synonymous with HIV testing.

Additionally, Tokhi et al, (2018) noted that men prioritized the gendered role of being a sole provider for the family and therefore their attention and involvement in family and reproductive health was limited. It can therefore be argued that male caregivers had some kind of phobia or fear for attending antenatal clinics with their wives during pregnancy as attested to by Kabanga et al for fear of establishing and disclosing their HIV/AIDS status. On the other hand, Tokhi et al. argues that men are taken by their roles as breadwinners of the family.

4.2.12: Father spending time with baby and family

Interviewers inquired whether fathers were spending more time with the child and family after the birth of their youngest child. It was noted that 59.8% (245) of the fathers were spending time with the child and 47.3% were spending more time with the entire family.

On average, 63.2% of the fathers spent at least 4 hours per week with the child and family. By implication therefore, there was more attachment to the youngest children after birth more than the entire family. Much as fathers gave attention to the entire family, they are more taken up the youngest ones in their respective households.

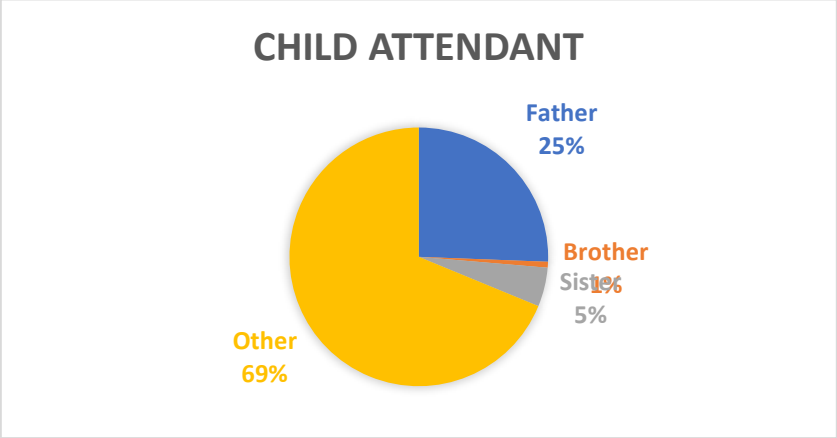
c) Data on Engagement

According to Olajide et.al, (2020), engagement was measured in terms of direct interactions and activities between the father and the child.

4.2.13: Caretaker of older children during the birth of the youngest child.

In South Sudan, the culture of male dominance had forced communities to view domestic work related to childcare as purely feminine. During the study, the researcher intended to know how much men were involved in childcare and therefore participants were interviewed on whether they had older children and if so, who took care of those children during the birth of the youngest child. 25.6% of the households remained under the care of the father during the birth of the youngest child. Despite being held back by culture, fathers had endeavored to embrace the ideal types of fatherhood they were expected to play.

Fig 3 – Data on Child Attendant



Source; field data, 2023

4.2.14: Father's involvement with care of the child

During data collection, participants were interviewed on actual activities that fathers were involved in with their children and participants were allowed to give more than one response.

Table 3.3 In which ways Fathers were involved with care of the child?

	Activity	**Frequency** (n=853)	**Percentage**
1.	Changing nappies	117	13.8
2.	Help mother when baby cries	256	30.0
3.	Playing with baby	243	28.3
4.	Washing baby	55	6.5
5.	Supporting with immunization	57	6.7
6.	Other	53	6.2

	• Financial help = 30 • Blank = 23		
7.	Never supported. • Still pregnant= 4 • Father not around= 8 • No support = 54	66	7.7
8.	No response	6	0.7

Source; field data, 2023

During the data collection process, participants were asked to give the exact activities that fathers engaged in with their children. This was because in many African cultures, men who engaged in antenatal care, housework and care of children were stigmatized as having been given a love potion (bewitched) or being mentally unfit (Motlagabo et al, 2018). Data collected revealed that 30.0% of the fathers were involved in helping whenever the baby cried, 28.3% played with their babies, 13.8% were involved in changing baby's nappies, 6.5% washed their babies, etc. 0.7% did not respond to that question and 7.7% reported that fathers had not engaged with their children**.** That meant that fathers play multiple roles at household level beside their gendered roles of fending for their families. The view put forward by Motlagabo et al, 2018 did not hold water given that some fathers were co-workers with mothers in pushing forward the household agenda of managing domestic chores.

4.2.14: Father's involvement with mother

Participants were interviewed on actual activities that fathers were involved in with their wives and again participants were allowed to freely express themselves with more than one response hence a frequency of 592 activities from 410 respondents.

Table 3.4 In which ways were fathers involved with their wives?

	Activity	**Frequency** (n=592)	**Percentage**
1.	Help with bathing	28	4.7
2.	Preparing meals	112	18.9
3.	Remind mother of health workers recommendations	236	39.9
4.	Not supported • Still pregnant = 3	43	7.3
5.	Other • Helped with house chores = 65 • Financial help = 83 • Carrying mother to heath center = 6 • Feeding wife = 2 • Hire/look for someone to help= 3 • Playing with wife = 1 • Prepare wife = 2 • Counseling support = 1	173	29.2

Source; field data, 2023

Although Motlagabo et al, (2018) had reported that while as some men believed that expressing love and supporting with some house chores was necessary, many held unto their cultural norms and expectations of providing financial support as the primary duty to their partners and believed that bonding with children was a woman's issue. The researcher got interested in ascertaining whether men in Imvepi camp supported their spouses after birth of the youngest child. The study findings indicated that 4.7% helped with bathing of the mother, 18.9% prepared meals, 39.9% reminded mothers on health worker's recommendations, whereas 7.3% reported to have not received or offered any support. 173 participants provided other ways in which they were supported e.g., 65 fathers were involved in house chores, 83 men gave financial support, etc.

d) DATA ON RESPONSIBILITY

According to Olajide et.al, (2020) responsibility was measured in terms of involvement with supervisory and parenting tasks, for example scheduling and following through medical appointments. To measure responsibility, data was collected on what stages of childcare fathers were more involved in decision making and whether fathers followed up antenatal and other recommendations by health workers. Participants were allowed to give more than one answer.

According to the study findings, 20.7% of the men were involved in decision making right from deciding to get pregnant, 25.5% were actively involved in making sure that their pregnant women attended antenatal clinic. On the contrary, 3.7% (29) reported that their spouses were never involved in decision making at any stage of child rearing.

4.2.15: Father's involvement in decision making.

Participants were interviewed on how fathers were involved in decision making at different stages of childbirth. They were still permitted to give more than one response, hence a frequency of 782 out of 410 interviews.

Table 3.5 How and what stage was the father involved in decision making?

	Stage	**Frequency** (n=782)	**Percentage**
1.	Decision to get pregnant	162	20.7
2.	Decision to start antenatal care	199	25.5
3.	Where to give birth from	68	8.7
4.	Decision on birth options.	41	5.3
5.	Decision on pain management during pregnancy.	77	9.9
7.	Choice of birth attendant.	57	7.3

8.	Infant feeding option	78	10
9.	Other	71	9.1
10.	Never Involved	29	3.7

Source; field data, 2023

20.7% of the fathers were involved right from the decision to conceive, 25.5% were involved when it came to starting antenatal care. Parental commitment had been cited as a facilitator to male involvement by Galle et al, (2019). When the pregnancy was planned, men were usually proud, prepared, and willing to engage.

It was worth noting that men were involved in activities related to financial provision since that was a gendered role for example, where to give birth, birth options, pain management options and infant feeding options. 3.7% of the men were never involved. That may be ascribed to the high levels of sexual abusive acts within humanitarian settings and the fact that several men travelled back to South Sudan to fend for the families. The small percentage of non-involved men implied that South Sudanese men in humanitarian settings were involved in maternal and child health issues than their counterparts.

4.2.16: Participation of fathers in antenatal visits.

Table 3.5 Did Fathers follow up on antenatal recommendations?

		# Antenatal visits attended by father				
		1-2	3-4	More than 4	None	Total
Did the father follow up antenatal		60	9	1	18	88
	No	5	0	0	99	104
	Yes	27	2	0	189	218
Total		92	11	1	306	410

Source; field data, 2023

The study findings also revealed that 218 (53.2%) of the male caregivers followed up on antenatal clinic recommendations. Of the 306 male caregivers who never participated in antenatal clinics, 61.8% (189) of these followed up on health worker's recommendations. 88 participants did not respond to the question. Following a study conducted by Motlagabo et al, (2018), men were expected to closely follow up antenatal recommendations since their expression of love was largely in terms of financial support. We therefore deduce that of the three aspects of male partner involvement, fathers were more involved in terms of sharing responsibility especially where responsibility called for provision of financial resources. Health workers' recommendations following antenatal clinics were often associated with provision. This alluded to work by Motlagabo et al, (2018) in which men believed that bonding with children was a women's issue and men were expected to provide financial support. Nonresponses to that question largely resulted from that fact that several men had travelled back to South Sudan to fend for families due to limited employment opportunities in the camp. That still may have been attributed to men embracing the responsibility of a bread winner or neglect associated with polygamy or the high rates of unwanted pregnancies resulting from sexual abusive acts that characterize humanitarian settings as mentioned by Jensen, 2019.

Educational status of Male Partner verses Pregnancy test attendance

		Present during pregnancy test		
		No	Yes	Total
Educational status of Male Partner		148	64	212
	Completed Primary	53	23	76
	Completed secondary	15	7	22
	Did not complete Primary	52	15	67
	Never enrolled in school	13	2	15

Tertiary	14	4	18
Total	295	115	410

Educational status of Male Partner verses # Antenatal visits attended by father

		# Antenatal visits attended by father				
		1-2	3-4	More_than_4	None	Total
Educational status of Male Partner		49	7	1	155	212
	Completed Primary	17	3	0	56	76
	Completed secondary	6	0	0	16	22
	Did not complete Primary	14	1	0	52	67
	Never enrolled in school	2	0	0	13	15
	Tertiary	4	0	0	14	18
Total		92	11	1	306	410

Source; field data, 2023

It was also noted that 42% of men who completed at least primary education were present during status and 35% attended at least one antenatal visit. Between primary and secondary, the more educated men were, the more involved they became. At tertiary level, less men were involved partly because at that level majority were involved in full time employment. That contradicted with Planalp and Braungart-Rieker (2015) findings in which it was noted that highly educated fathers provided higher levels of verbal stimulation and were more involved. The more educated fathers got, the more information but also the more engaged in employment world.

4.2.15: Male Partner support during pregnancy.

Respondents were interviewed on how male partners supported their wives during pregnancy. Respondents were allowed to give more than one answer hence a frequency of 1,225 from 410 interviews.

Table 3.7 In what ways were fathers involved with care of the wife during pregnancy?

	Activity	**Frequency** (n=1,225)	**Percentage**
1.	Arranging transport to hospital	276	22.5
2.	Remind wife about antenatal recommendations	124	10.1
3.	Remind wife about health worker's recommendations	157	12.8
4.	Ensured adequate rest during pregnancy	108	8.8
5.	Ensured proper nutrition	107	8.7
6.	Supported with home chores	74	6.0
7.	Supported with care of other children	66	5.4
8.	Finding information about pregnancy and childbirth	32	2.6
9.	Financial support	196	16.0
10.	Other	64	5.2
11.	No support	21	1.7

Source; field data, 2023

Participants were interviewed on how male partners were involved/supported their spouses during pregnancy. 22.5% of the fathers supported in terms of arranging transport to hospital, 16% provided financial support and 22.9% reminded them about health workers recommendations either on general health or antenatal. 8.8% ensured that the mother got adequate rest, 11.4% supported with home chores including care for older children. This alluded to cultural norms and expectations where men's primary duty was to provide financial support (Motlagabo et al, 2018). It was rather worth noting that 20.2% of the respondents reported direct support in terms of reducing the mother's workload at home. According to the data, it was noted that men had continued to uphold their gendered role of a bread winner but also many had acknowledged the importance of other aspects of male involvement e.g.,

reducing workload at home. This was a positive signal towards having an involved father. It was also clear that change of environment coupled with sensitizations by development partners had a big impact of negative cultural connotations associated with pregnancy and childbirth e.g., 11.4% of men supporting in home chores. That implies than men were willing to change if given the right information.

e) PRESENTATION OF QUALITATIVE DATA

Qualitative Data analysis was collected concurrently with quantitative data using focus group discussions and key informant interviews. A total of 12 FGDs and 3 KIIs were conducted with community members, leaders, and health workers. The FGDs and KIIs specially collected data on barriers, facilitators, and the effect of a humanitarian setting on male partner involvement.

Data on effect of a humanitarian setting on male partner involvement.

The researcher interacted with participants in FGDs, KIIs and with some individual participants to ascertain the effect of a humanitarian setting on male partner involvement, data collected revealed that,

1. Research data revealed that a humanitarian setting had a positive effect on male partner involvement largely through sensitizations by development partners and health workers. Ultimately, men had embraced more peaceful ways of resolving conflicts in homes i.e., reduction in violence in homes (21%), men were actively involved in supporting their wives with house chores and childcare (27%). Participants reported blending of cultures had improved love and care between spouses (18), specifically, men were actively involved in originally and culturally feminine activities like cooking, fetching water, bathing children, taking children for healthcare, and accompanying their women to hospital. Male children were also involved in sweeping the

compound and other domestic chores. CARE INTERNATIONAL was specifically sited out as being actively engaged in positive mindset change in communities. Male participant number 7324 mentioned that ***"we can at least have time for our children and share family responsibilities with my wife"***. Participant number 7350, reported that, ***"At least I'm no longer a violent man in the house, I have reduced my drinking habit due to the teachings I got from the community"***. Information desks for reporting complaints were also cited out as important interventions that had increased love and understanding in families and free access to health facilities had enabled fathers to confidently support their children access healthcare. Male participant number 7371 reported that, ***"We are able to adjust the bad behaviors and change immediately to inflict good character in the house so that our children copy from us. Argument have totally reduced due to the knowledge we got."*** Female participant number 7336 mentioned that "***There is too much love and understanding in some families due to the changes brought by humanitarian settings."***

2. On the contrary, humanitarian setting had negatively affected male involvement due to high levels of poverty resulting from lack of a source of income coupled with inadequate farming land and reduction in food supplies by World Food Program. This had increased fights in many families (10.1%). Some fathers were not able to support their spouses because they had to work so hard to earn something small. Additionally, the cost of living was very high (items are very expensive). There was no intentionality by development partners to support men. Priority had been given to women and children. Fathers were not able to provide for their households and yet the women were

continuously making demands. Inadequate nutrition due to limited supplies provided by world food program was another factor that had contributed to increased gender-based violence in homes.

3. On the other hand, 22% (90) of the participants reported that the humanitarian setting had not affected male partner involvement among South Sudanese in Imvepi camp.

4.2.17: Data on Perceived Facilitators.

Participants were asked to share factors that had facilitated or enabled male caregivers to participate in maternal and newborn health care. To exhaustively collect data on perceived facilitators, this was an open-ended question and hence participants were free to give more than one answer hence a frequency of 640 from 410 one on one respondents, 8 FGDs and 3 KIIs.

Table 3.8 What do you think has facilitated male partner involvement?

	Perceived Facilitators	**Frequency (n=640)**	**Percentage**
1.	Availability of income generating activities	97	15.2
2.	Presence of Development partners	1	0.2
3.	Health relationships between partners.	19	3.0
4.	Access to a health facility	139	21.7
5.	Access to free health services	96	15.0
6.	Community dialogues and awareness training on maternal and child health e.g., women's desk	139	21.7
7.	Access to free food and other non-food items	61	9.5
8.	Access to a market	32	5.0
9.	No activity to keep them busy	1	0.2
10.	Good services at the health center	3	0.5
11.	Education level of male partners	16	2.5
12.	Modernization/ Mindset change/ Diversion from cultural practices	35	5.7
13.	Ill health of the wife	1	0.2

Source; field data 2023

During the study, participants were interviewed on factors that had facilitated male partner involvement in a humanitarian setting. 21.7% attributed it to accessibility of health facilities and awareness creation on maternal and child health. Access to free health services (15.0%) and other necessities (9.5%), availability of income generating activities (15.2%) was among other facilitators. This concurred with results of the study conducted by Redshaw and Henderson (2013) where economic consequence was cited as a key consideration before men made decisions to be involved in maternal and newborn health issues.

4.2.18: Data on Perceived Barriers

To ascertain perceived hinderances to male partner engagement in maternal and newborn health, participants were interviewed on factors that hindered men from being actively involved. To exhaustively gather data on perceived barriers, participants were allowed to give more than response hence a frequency of 738 from 410 interviews and 8 FGDs and 4 KIIs.

Table 3.9 What do you think hinders men from being involved?

	Perceived Barriers	**Frequency (n=738)**	**Percentage**
1.	Financial constraint or Poverty	246	33.3
2.	Long distance to health center	58	7.9
3.	Commitment at work	23	3.1
4.	Culture/polygamy	65	8.8
5.	Inadequate health care at the facility	57	7.7
6.	Inadequate training on maternal and child health	40	5.4
7.	Unhealth relationship between the couple	60	8.1
8.	Drug abuse e.g., alcoholism	27	3.7
9.	Low education levels	59	8.0
10.	Inadequate food provided	41	5.6
11.	No attention/support given to men by health centers and development partners	39	5.3
12.	Limited capacity by development partners	23	3.1

Source; field data 2023

Financial constraint was a key hinderance attributing to 33.3% of the barriers. Other barriers included long distance to the health center (7.9%), cultural norms (8.8%), unhealthy relationship between the couple (8.1%) and low levels of education among male partners (8.0%).

This implied that men could have been willing to participate but they were overwhelmed by the responsibility of a bread winner. This is escalated by the fact that humanitarian settings provided limited opportunities for employment hence most men did not have financial resources to execute that desire role. Additionally, the more inaccessible a health facility was, the more financially draining it was especially for households that are financially constrained.

Although commitment at work was noted as one of the barriers by 3% of the respondents, it should be noted that there was no difference in male involvement in antenatal clinic between unemployed (26%) and employed men (25%).

Employment status of Male Partner verses # Antenatal visits attended by father

		# Antenatal visits attended by father				
		1-2	3-4	More_than_4	None	Total
Employment status of Male Partner	Fully Employed	1	0	0	2	3
	Not Employed	68	7	1	222	298
	Partially Employed	9	4	0	26	39
	Self Employed	14	0	0	56	70
Total		92	11	1	306	410

Data Analysis

Objective 1: Level of male partner involvement in maternal and newborn health among families in selected zones in Imvepi refugee settlement.

To establish the level of male partner involvement, analysis of data on availability, engagement and responsibility was done.

In terms of availability, participants were interviewed on whether the father was present during the pregnancy test, whether the father participated in any antenatal visits and if so, how many, birth attendant during childbirth and whether the father was spending time with the child and family.

Regarding presence during the pregnancy test, 28.08% (115) of the male caregivers were present. Urban households (zone 3) had more (31.2%) fathers present compared to their counterparts in rural areas (25.8%). This agreed with the results of a study conducted by Kabanga et al, 2019 where it was noted that the prolonged waiting time at hospitals as well as distance to the health facility limited male partner involvement in maternal and child healthcare.

In terms of antenatal attendance, 25.4% of the fathers participated in at least one antenatal clinic. 0.2% of the fathers participated in more than 3 antenatal clinics. Despite the fact that focus group discussions and key informant interviews reported that a humanitarian setting had positively affected male involvement through attitude change, lack of clarity of the role of fathers during pregnancy and newborn care was still a hindrance. 5.4% of the participants reported inadequate training on maternal and child health by development partners. Galle et al, 2019 had alluded that the training content for Maternal and Child Health (MCH) nurses paid attention on women and children, with no definite attention paid to the role of men or their unique health needs such as inguinal hernia and prostate problems. Furthermore, study results on hinderances to male involvement cited cultural beliefs (8.8%) as one

of the factors for example pregnancy and newborn care considered a women's space as noted by Panyin et. al, 2017.

Whereas humanitarian settings were characterized by informal marriage patterns resulting from broken family relationships, only 17.3% of the fathers were present in hospital during the birth of their youngest child. 81.9% of the fathers who were not present at the health facility during childbirth, were neither involved in decisions around choice birth attendant nor were 77.3% caretakers of older children.

Whereas citizens gave work commitments as a common hinderance to father's involvement according to Sakala et al, 2021, men in a humanitarian setting like Imvepi would be expected to spend long hours with their family members since only 19.9% were employed (Uganda - Refugee Statistics July 2021 - Imvepi) and only 0.7% of the sampled participants were involved in full time employment. According to the study findings 40.2% of the men were not spending time with their newborn children. Mari (2014) had noted that the dominating influence of mothers-in-law during late pregnancy and shortly after childbirth discouraged paternal involvement in decision making processes as mothers-in-law disregarded their contributions in pretext that they were not experienced and had little knowledge. During the study, it was noted that 35.2% of the birth attendants were mothers-in-law. According to the study findings, it was noted during focus group discussions and key informant interviews that many men had travelled back to South Sudan after settling their families due to lack of a source of income and limited land for cultivation.

Like all other men, fathers in humanitarian settings were still stuck to the original role of bread winner to being an involved father as presented by one of the participants in FGDs, "*For us we have many things we help women with, first for*

women who are pregnant what is needed is good feeding, if there is no feeding the body reduces and baby inside her also reduce in her stomach but if she feeds well the baby also is good in the stomach."

It was worth noting that, 18.9% of the men participated in preparing meals for their household members during pregnancy as well as following up and ensuring that health worker's recommendations were fully implemented. This rallied with a submission made by participants during one of the FGDs that a humanitarian setting had enabled them to realize that their women were overburdened by house chores and needed support.

In terms of engagement (direct activities that fathers were involved in), 30.0% were involved in soothing their babies whenever they cried and 28.3% played with their children. It was worth noting that although cleaning was largely a feminine role, 13.8% of the fathers participated in changing nappies and 6.5% were involved in bathing their babies. This was contrary to what Mari (2014) reported that maternal and newborn health spheres were totally under the influence of women with men playing a very limited or no role at all. According to Mari 2014, men were not supported to perform care tasks like breastfeeding, cord care and bathing which limited physical contact with the newborn. Similarly, Tobijo et al, (2021) had reported that in South Sudan, the culture of male dominance had forced communities to view domestic work related to childcare as purely feminine.

When assessed on engagement with women, data revealed that some fathers were involved in feeding their spouses while others had time to play with them. This tallied with the data reported on facilitators in which 5.7% of the participants reported mindset change and 3.0% health relationships with spouses as facilitators to male

partner involvement. This was largely attributed to community dialogues and activities conducted by development partners in ensuring peaceful living as well as integration with host communities.

According to data collected from health workers attending to mothers and children, on average 6-10% of the men participated in antenatal and childbirth activities. This was attributed to long distances to the health center and limited knowledge of maternal and newborn health challenges. Since these health workers had served in different places, they were asked to compare male partner involvement in a humanitarian setting specifically Imvepi to that of citizens and host communities. The team reported that, male involvement was low for example, "*Male partner involvement in Imvepi is too poor because of the perception and norms they have.*"

Although access to free services and other non-food items like soap, materials for shelter construction, mattresses, mosquito nets etc. facilitated male involvement as reported by 9.5% of the respondents. Implying that relieving male partners from the burden of providing for the family would translate into them being more involved fathers. On the contrary, 72.9% of the respondents whose male partners were not employed, they were also not actively involved in maternal and child health matters as reflected by antenatal and childbirth attendance. Participants also alluded to the fact that unemployed men had more time to interact with the family members, "*To me male involvement in the camp is better than that in our country because here we have leisure time to spend with my wife or even carry the baby. Or fetching water for domestic use but in South Sudan everyone is busy.*"

Based on the above analyses, male involvement in maternal and newborn health among families in selected zones of the Imvepi refugee settlement was low even

though, many were not involved in fulltime employment, health facilities were closer compared to other parts of the country and health services were provided at no cost. This was largely attributed to culture which emphasized provision as the major role of fathers in childcare.

Objective 2: Perceived facilitators/enablers of male partner involvement in maternal and newborn health among families in South Sudanese selected zones in Imvepi refugee settlement.

Activities of Developmental Partners in communities

Data showed that organizations and other development partners working in camps had a significant impact on improving male participation in maternal and newborn health among families in humanitarian settings. These facilitated community dialogues and health sensitizations with an objective of improving the wellbeing of refugees specifically women and children. Participants reported that those engagements influenced beliefs and attitudes of refugees thereby influencing how they responded. Women's desk facilitated peaceful conflict resolution in families, and that contributed to reduction in domestic and gender-based violence as well as fostering family unity and respect for one another. Community dialogues were reported as a facilitator by 21.7% of the participants. Community leaders who participated in FGDs reported that "*Awareness sessions are always organized to help the women know what to do during that period. Partners are also doing trainings on male involvement. Because of culture men fear going to health facility but Men are now walking to the health facility."* During an FGD with married mothers, one of the respondents reported that "*To me TPO is doing great work because they bring people together both men and women and give advice on how to stay well and take* good care of our families that's TPO."

Development partners had also facilitated integration of the refugee community with the host community. During these engagements, refugees had been able to learn from and were being influenced by the host community. During FGD 6, participants reported that "*Sensitizations and organizing football between refugees and host community has enabled us learn from what they do, and some men are doing the same*".

Accessibility to health facilities and free health services

21.7% of the facilitators to male involvement was accessibility of the health facility. FGD 4, one of the respondents reported that "*Here the hospital is near with an ambulance but in our country the hospitals are far so sometimes we can't escort our wives to hospital.*" Additionally, 15.0% of the participants reported that access to free health services was an enabler to male involvement as fathers had the confidence to support their household members to hospital without fear of financial repercussions. This aligned with what Panyin, Kwame, and Tuoyire (2017) recorded that, men who were financially constrained tended to isolate themselves from maternal and child health issues. The provision of health services at no cost was recorded was a big relief for the refugees. A VHT during a KII noted that *"Organizations like ARC has done good in bringing medicine. Since we came in 2017, I worked with many organizations am a VHT. In the hospital the organizations encourage the woman to take family planning and others end up taking without the consent of the husband which is bad. To me these organizations have done good and also bad at the same time as others encourage the woman to be against their husband."* Another participant during an FGD with male caregivers reported that

"MSF help us with sick children especially the ones with epilepsy, they give us medicine for free and most cases the children improve."

On the contrary, 3% of the mothers reported that men had settled for free things hence many were lazy and had resorted to alcohol abuse instead of working. During a FGD with married women, participants were interviewed on whether a humanitarian setting had affected male partner involvement, one of the participants said "*To me it's a yes, because we have hospital near, we get medicines, children are screened for malnutrition in the homes, so this has left out men from helping us because they see that we are being helped. The men feel that children are being given supplements, medicines are for free, so they feel reluctant in helping us."*

Availability of income-generating activities.

According to research data, 15.2% reported availability of opportunities to earn as a facilitator to male involvement. The patriarchal nature of South Sudanese community placed men as key decision makers in family matters not limited to deciding when and where the women should go to seek for antenatal care, delivery, and postnatal care as well as childcare through provision of financial support. Kariuki and Seruwagi, 2016 had alluded that, men still prioritized the role of a bread winner to being an involved father. It was also noted during FDG 8 as one of the participants shared that "*To me also, announcements by happy organization when distributions are near makes our work simple as its not abrupt, we become aware of when to go for distributions."*

Participants reported that there was available land within the host communities for hire. Although hiring land was reported to be expensive, participants appreciated that it was available to whoever could afford it, and this was used to supplement

food relief as well as income. For example, one of the participants in a KII with leaders reported that, "*getting money for us to help people at home, we get through these ways like when you buy a place from the host community, you dig some crops and sell the other portion of crops at least you can get something small which we can use to support our families here in the camp. That's how we survive*."

On the other hand, refugees reported that there were limited job opportunities for the uneducated coupled with exploitation by development partners and host communities through unfair payments for the work done. This could be attributed to Uganda's value for money compared to South Sudan as well as the cost of living. The cost of living in Uganda was 17% higher than South Sudan.

From the research data, it was noted that 5% of the participants presented access to market as one of the facilitators to male involvement. Through probing on access to the market participants mentioned that they was available market for their products especially food and other basic needs. Imvepi refugee camp like all the other humanitarian settings was characterized by high populations and it is located away from the town (estimated at 82 Kms from Arua town) which made access to other markets hard. The high population within camps provided a ready market for domestic items and food. Refugees were able to sell off their goods but also those who needed items not provided for under humanitarian assistance like clothes were served. This facilitator was mainly presented by men due to the cultural connotation of the responsibility of providing for the family.

Objective 3: Perceived barriers that hindered male partners from actively participating in maternal and newborn health among families in selected zones in Imvepi refugee settlement.

Financial incapability/poverty

When participants were interviewed on barriers to male partner involvement, 33.3% presented financial incapability was a major hinderance. This was largely because men still viewed the role of a bread winner as being key. For example, during an FGD with male participants were interviewed on how they were supporting their wives during pregnancy and after childbirth, one of the respondents submitted that "*I buy soap for her to wash babies' cloth, if sickness I buy medicine for the baby so that the baby grows up well.*" Participants reported that health workers made unnecessary demands whenever men escorted their women to hospital and fathers were harassed whenever they were not able to meet those requirements, for example, *"For me lack of money is the one that makes me not to follow my wife to the hospital, when I go with her the nurses say buy clothes, buy bag or buy basin all this I can't have money for buying making me to fear or buy gloves. That's why we leave them to deliver from home, a times she might be referred to Arua and no one to follow those are the reasons."* Another male participant said, "*When I go for delivery, they first check the clothes in the bag and carpet when it's not the one they want they say buy another which cost 15000shs, where will I get the money. Secondly the clothes they say ooh this is not good, but this is what I can afford that's why we fear to deliver from the hospital."*

This was escalated by limited employment opportunities in the camp specifically the uneducated as well as exploitation in terms of low payments. Participants reported that, "*To me there are no factors, because men are to help when they have*

something to do but here in the camp, there is labor for work but it's the host community doing. Lack of work to do. Lack of money, being under paid here when we do labor for work maybe UgShs.1,000 or UGShs.500 and for men they end up using it for alcohol. But if organizations were to give them casual work would have been better. But here most jobs are given to Lugbara, Alur or other nationals that's why staying here has many challenges.". Limited job opportunities in humanitarian settings had made many refugees to live a desperate life, many men were not comfortable with a lifestyle of waiting to be provided for and hence several men had returned to South Sudan to fend for their families. A midwife at one of the health centers reported that although sensitizations had been done and many men encouraged to support their women during pregnancy and childbirth, some men had travelled back to South Sudan. Different respondents during focus group discussions mentioned that their husbands were not around, they had moved back to South Sudan and therefore could not support. This was how some respondents alluded to that "*He also buys free ware or give money when am sick for treatment and escort me for antenatal but only if he was around. But the challenge here our men are not here."* "*If he was around, he would buy medicine for the child or if the baby is crying, he could also carry."* "*Also, if he was around, he could escort me for delivery at night, but now he is not around so I put my baby on the back and go to the hospital. He could also sign some documents during delivery, but he is not present."*

Cultural connotations associated with pregnancy and childbirth.

Data revealed that beliefs that associate pregnancy and childbirth to women had hindered male involvement. Fathers believed that pregnancy and childbirth was a feminine closet. This rallied with the fact that of the 363 mothers who selected other

on birth attendant, 112 of the birth attendants were mothers-in-law. During FGDs, one of the participants mentioned that "*What makes our men fear to escort us to hospital is, they are chased away they only needs a woman even if they do transfer, they say let a woman escort that's why when we are going for delivery our men feel like a woman should be the one to take us."* One of the fathers also said that "*They also chase the men they demand for two buckets that's why the elderly women are the ones who escort us."* Tobijo et al, (2021) had reported that social sensitivity towards women after childbirth discouraged fathers from sharing a room with a breastfeeding mother for the first two years after childbirth.

Although 5.7% of the participants had presented mindset change or acknowledgment of negative cultural practices as one of the facilitators, some men were still held back by culture. Among the cultural practices that hindered male partner involvement was polygamy. According to Wikipedia, 40% of the families in South Sudan were polygamous. During the study 36.8% of the sampled participants were living in polygamous families and 8.8% presented polygamy as a big challenge. Galle et al, 2019 had noted that complicated relationships associated with polygamy and extramarital relationships were potential hindrances to male involvement. It was noted that polygamous men preferred to stay with a wife who was not pregnant to avoid demands associated with childbirth.

Mistreatment of men by health workers and neglect by development partners.

Data shows that men in Imvepi camp did not receive enough support to enable them to execute their roles and responsibilities in addition to being mistreated by health workers. This also included being held responsible over issues that they as men seemed to have no control for example a participant in one of the KII mentioned

that, "*Another thing is being undermined or belittled, when I escort my wife for antenatal some nurses say how do you allow your wife to come with dirty dress and yet a times it's because we do not have money for buying new one. This discourages us from going to the hospital.*"

In terms of support to men, participants mentioned that majority of the development partners had prioritized support to women and children. One of the male participants mentioned that *"Here organizations mostly help women, they don't support men to help their women." One of the participants reported that through support from development partners, some women are given money, and this had caused violence in homes for example, "Some women when given the cash they use it form drinking alcohol, others if they have money, they undermine the husband."*

It was noted that the host community was not supportive of the refugee community and that had made the life of refugees harder especially in terms of income generation for example "*To me there is oppression/ mistreatment from the host community that's why we can't get other services, because you know as being a refugee you are no entitled to do other jobs like it used to be in South Sudan to me its oppression."*

Unsatisfactory services at health centers

Inadequate care at health facilities was reported by 7.7% of the respondents. It was also noted that some of the healthcare services being provided were not culturally and socially sensitive for example a nurse from the health center reported that many men had refused their women to take on family planning because the men desired to have many children to replace relatives who died during the insurgency. This was confirmed by one of the male participants as follows*, "Others put family planning*

without our notice, when she has put you can't remove and yet the primary aim of marrying her was to give birth and expand the family because some peoples born alone in their family." A VHT mentioned that *"hospitals and other organizations encourage women to take family planning without the consent of the husbands which is bad as it this encourages the woman to be against their husband."*

Some participants also complained of incompetent health workers, they cited examples where health workers failed to remove family planning implants when spouses were ready to have another child and that the mothers were not referred to other facilities for support for fear of being noticed as being incompetent. This had caused family wrangles especially amongst households where the husband was looking at replacing his relatives who died.

Despite reports on improvement of healthcare service delivery in humanitarian settings, participants reported shortage of essential drugs. This was presented with a lot of pain during FGDs as many people faced challenges of having to buy drugs outside the health center coupled with the high poverty levels. This had brought mistrust in healthcare services, and many had resorted to using herbal medicine and traditional birth attendants or private clinics rather than forbearing the long queues and again one is referred to a clinic, "*when you go to the hospital, they refer you to the clinic. When you don't have the money, you have to stay back home cause of fear of lack of money."*

5.0 DISCUSSION OF RESULTS

5.1 Level of male partner involvement.

Generally, the level of male partner involvement among South Sudanese families in humanitarian settings was higher compared to their counterparts. Despite the high poverty levels among refugees resulting from fundamental shifts in economies, disruption in education, breakdown of family structures and informal marriage patterns as well as lack of stable employment and income generating activities in refugee camps hence more severe cases of gender-based violence with fewer options of leaving a violent relationship. According to Shefaly and Lina (2019), such unhealth spousal relationships influenced father-infant relationships and ultimately male partner involvement. Development partners within Imvepi camp were reported to have managed domestic violence cases through community dialogues as well as conducting sensitizations on the importance of male involvement and obstetric and newborn emergencies as well as complications associated with pregnancies. Resultantly, 21% of the respondents revealed that men had embraced more peaceful ways of resolving conflicts in homes. Hence, 28.5% of the men were present during the pregnancy test, 22.4% attended at least one antenatal clinic, and 18.9% were involved in preparing meals after childbirth. 20.7% of the men were involved in decision making right from deciding to get pregnant, and 25.5% made sure that their pregnant women attended antenatal clinic.

Education status of the male partners did not have impact of involvement as 42% of men who completed at least primary education were present during pregnancy testing and 35% attended at least one antenatal visit. At lower levels, between primary and secondary, education improved involvement but beyond secondary men

became less involved. It must be noted that participants complained of lack of jobs for the non-educated, implying that the more educated men were the more involved at work. Some highly educated men had travelled back to South Sudan to secure their jobs and left families in Uganda.

Young parents (16 -35 years) were also found to be more involved compared to old and experienced fathers (36 years and above). 25% of the young fathers attended at least one antenatal clinic compared to 13% of the experienced fathers. This agrees with what Redshaw and Henderson (2013) had reported that partners of these first-time mothers with planned pregnancies were slightly more involved. It should be noted that most of the experienced fathers were living in polygamous families characterized by enormous family responsibilities amidst constrained resources.

This improvement in the involvement of male partners could be attributed to mindset change related to cultural connotation around childbirth and gendered roles of men as reported by 5.7% of the respondents. Participants in focus group discussions reported that men had changed a lot including involving themselves in home chores and care for the children which was unheard of in South Sudan. The strong patriarchal and polygamous communities hindered many men in South Sudan from being involved.

From the above findings, it should be noted that south Sudanese men in humanitarian settings were more involved in maternal and newborn health compared to their counterparts as reflected by their participation in culturally feminine activities like home chores and childcare (27%). The fundamental shifts associated with humanitarian settings had affected other factors associated with male partner involvement e.g., education level of male partner, employment status, etc.

5.2 Perceived facilitators to male partner involvement.

The observed improvement in male partner involvement could have been attributed to the fact that humanitarian settings offered free healthcare services. Childbirth was a costly venture, requiring substantial amounts of financial resources from the time a pregnancy was confirmed hence men who were struggling financially tended to isolate themselves from such expenses as a way of protecting their identity and esteem. Although refugee hosting districts were among the least developed hence an additional stress on the already constrained healthcare system, government with support from development partners had greatly improved healthcare service delivery in refugee hosting districts. Men in Imvepi had the courage to support their family members access health services irrespective of their financial status. Out of pocket expenditures were cited as one of the greatest hinderances to accessibility of healthcare services globally.

Despite the fact that health services were provided at no cost, health service delivery in Uganda was still associated with numerous indirect costs that many refugees could not handle had there not been a variety of income generating activities within the camp. 15.2% of the participants attribute male participation to the fact that they had some financial resources to facilitate healthcare whenever called for. The high populations in refugee camps provided market to many goods and services. Men who were constrained financially shied away from supporting their household members to seek healthcare for the sake of protecting their dignity as heads of households.

Additionally, accessibility of the health centers facilitated male partner involvement. The long waiting time in addition to unbearable distances to health facilities had hindered fathers from being involved. This explains why urban

populations (zone 3) had more fathers present during the pregnancy test compared to their counterparts in rural settings (zone 2). Imvepi refugee camp hosting 69,198 refugees (UNHCR 2021) and the surrounding host communities were being served by two fully equipped health facilities.

According to field data, it should be noted that 72.7% of the men were not employed. The high unemployment rates associated with humanitarian settings was a factor that cannot be ignored. Work-related commitments associated with the gendered role of a breadwinner had been cited as one of major barriers to male involvement as men were expected at work most of the time and many could not secure adequate time for paternity leave. In a refugee camp where only 19.9% of the people were employed, men had fewer excuses for not supporting their family members.

Exclusion of men from maternal and childbirth related sensitizations had hindered men from making informed decisions as well as active involvement. In refugee settings, community members were largely available whenever called out for community dialogues. Health and development workers had improved men's awareness on obstetric and newborn concerns hence laying a strong foundation for their involvement. Women mentioned during focus group discussions that there had been improvement in respect and love for women following sensitizations within communities.

From the data collected, it should be noted that men can actively support their households if they were sensitized on their importance as well as on the dangers of some of the cultural norms associated with women and childbirth.

Generally, of the three facets of male partner involvement (availability, engagement, and responsibility), men in humanitarian settings were more involved

in terms of sharing the responsibility of childbearing for example 61.8% offered financial support (transport to hospital, ensuring meals and direct financial assistance). Men were also reported to be involved in decision making and following up on health worker's recommendations (22.9%). This aligned with the socio-cultural and gendered role of men as sole providers for the family with limited responsibility on actual interactions with family members. It also explains why financial constraint was submitted by 33.3% of the participants as a key barrier.

5.3 Perceived barriers to male involvement.

Despite of improved accessibility to health facilities, it was noted that the long waiting time during antenatal clinics discouraged men from being actively involved in maternal and child health issues as some had to involve themselves in income generating activities to support families. Imvepi refugee camp alone had a population of 69,198 (UNHCR 2021) minus the host communities. This total population was served by two health centers, Imvepi health center 11 and Yinga health center 111. In Uganda, a health center 11 was expected to serve 5,000 people and health center 111 to serve 20,000 people. This implied that despite improvement in health care services, the two health centers are overwhelmed by the big numbers of people to serve. Overwhelmed health centers explain why 7.7% of the barriers to male involvement were attributed to inadequate healthcare services.

This aligned with Nyasiro S. Gibore et. al 2019 findings which revealed that the longer the time men spent waiting for health services, the less involved they became. This was worse with employed men in paid workforce as many were not able to spend close to an entire day engaging in antenatal clinic neither did, they have access to adequate paternity leave to support their wives shortly after childbirth. Research

data revealed that only 25% of employed men (fully employed, partially employed and self-employed) participated in at least one antenatal clinic. This implied that male partner involvement was negatively correlated with employment. On the contrary, although majority of the male partners were not involved in any form of employment, 74.5% of these were never involved in any antenatal clinic. Additionally, 52.7% of fathers did not spend more time with their families after the birth of the youngest child.

It was also worth noting that 30.0% of the men were involved in care of the baby. According to the data, 61% of the fathers were not involved until the baby was 3 months old. This agreed with the socio-cultural connotations attached to newborn care that hindered men from closely attending to their babies coupled with reports from educational curriculum experts which revealed that the training content for maternal and child health nurses largely paid attention to women and children with no specific focus given to the role of men (Galle et al, 2019). This meant that most men lacked clarity of what was expected of them during the earlier stages of their children besides provision.

Unsatisfactory health services: 7.7% of the participated expressed dissatisfaction on the quality of health services provided. Some men resorted to supporting their family members using herbs because of the poor services. It should be noted that whenever people were not satisfied with the quality of the service/product, they did not use it irrespective of the cost.

It was worth noting that with the coming of women emancipation and the girl-child, men and boy children had suffered neglect and violence. 5.3% of the participants reported neglect by development partners as majority of the programs focused on

building capacity of the girl-child and women leaving men behind and incapacitated. Although men were still expected to provide for their households, no support that been given to them given the fundamental shifts in economies.

6.0 CONCLUSIONS AND RECOMMENDATION

Conclusions

Generally, it was noted that South Sudanese men in humanitarian settings were slightly more involved in maternal and child health issues in comparison to their counterparts. It was noted that sensitization on the importance of male partner involvement by development partners, coupled with support from health workers greatly influenced both the attitude and subjective norms (social expectations/pressures) of men towards male involvement. Perceived behavioral control which was largely influenced by socio cultural norms changed resulting from breakdown of family structures because of migration. For example, whereas inn South Sudan it was believed that a man was supposed to sleep in the same room same room with a breastfeeding mother for 2 years, in the camp, there were not many options or rooms. Additionally, many families did not have mothers-in-law to attend to a mother shortly after childbirth as the norm was in South Sudan. This meant that fathers had to take on the responsibility which enhanced their involvement.

Tobijo et al, (2021) noted that social sensitivity towards women after childbirth discouraged fathers from sleeping in the same room with a breastfeeding mother for two years.

Accessibility to health centers and free health services coupled with sensitization given to men on the importance of their involvement were key facilitators.

Financial constraints, cultural connotations attached to pregnancy and childbirth as well as time invested in accessing healthcare were the major barriers.

Recommendation.

It was noted that the more men were sensitized on maternal and child health issues, the more involved they became. I therefore recommend that more efforts should be invested in sensitizing communities on maternal and child health issues clarifying how each stakeholder including men can make meaningful contribution towards reducing maternal and child mortality rates in sub–Saharan Africa.

Areas for further Research

The study focused only on the Factors Affecting Male Partner Involvement in MCH among Families in Humanitarian Settings: a case study of Imvepi refugee camp. It is therefore recommended that similar research be extended to other levels and dimensions of other refugee camps for comparative analysis.

The research study was premised upon a small geographical area and one refugee camp. There is need to widen the scope of this study and replicate; subsequent studies should be undertaken in a rather wider geographical area and with more refugee camps elsewhere in Uganda like Nakivale among others. This could throw more light in the context of Male Partner Involvement MCH among families in humanitarian settings.

I also recommend that more research be done to ascertain the relationship between time spent in humanitarian settings and behavioral change.

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APPENDIX

Appendix 1

i. Consent Form in English

Factors affecting male partner involvement in maternal and child health among families in humanitarian settings. A case study of IMVEPI refugee camp.

Consent to take part in research.

- I…… voluntarily agree to participate in this research study.
- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.
- I understand that I can withdraw permission to use data from my interview within two weeks after the interview, in which case the material will be deleted.
- I have had the purpose and nature of the study explained to me and I have had the opportunity to ask questions about the study.
- I understand that participation involves one on one interviews or focus group discussions or key informant interviews (*participant will mention any of the three data collection methods that he/she will be requested to participate in).*
- I understand that I will not benefit directly from participating in this research.
- I agree to having my interview being audio-recorded.
- I understand that all information I provide for this study will be treated with confidentiality.
- I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details

of my interview which may reveal my identity or the identity of the people I speak about.

• I understand that disguised extracts from my interview may be quoted in the report, conference presentation during defense, or if the paper is published etc.

• I understand that any signed consent forms, original audio recordings and a transcript of my interview will be retained in a secure location where only the researcher has access until the research report is approved by the university research ethics committee and results approved by the university senate.

• I understand that I am free to contact the researcher (Allen Namazzi,) to seek further clarification and information. Mobile phone: +256776974793/256701974796, email: allenkatongole@gmail.com.

Participant' signature/thumb print _____ Date _____

Participant's code: _____ Zone_____

Signature of the Data Assistant_____ Date_____

ii. Consent form in Bari

Kusik na mogga ŋutu lyan I morakindya I kulya, I gwon a kayuŋonit ko meta na kelan na gurö, I kiden na midijik, I togwi'diesi ti mugunya na meddya kulya ti ŋutu.

Kusik nagon galwe kaŋo I kem na imvepi.

- Nan---------- ---------- a ruk Morakindya I ga'yu na na to'diri kode I titimba na kulya anyen kukure.
- Nan a kurun adi, ma'di ko nan a ruk I Morakindya soŋinana, nan bubulö ko'yu I diŋitan liŋ kode renya I ruggö na pipiesi 'bak kune ri'diesi kode saresi logon a tetena.

- Nan a kurun nagon adi nan bubulö renya ruket nio na pipiesi I yökiet na tomoret na rörö logon a kulyaet I mukok na jimalan murek I mukok na piesi, köti nagon adi kine wuresi bubulö siyaji kaŋo.
- Nan a gwon ko tirikwet ko mugun, ko tokoresi ti na denuet a tokurukin nan, köti nan gwon ko töilyen I pija na piesi I lokit na na denuet.
- Nan a kurun adi, ŋina Morakindya tomorja piesi I loki na ɳutu geleŋ I ɳutu geleŋ, kode jamesi I teŋ na ɳutu logon a momorja I ŋarju na kulyaesi kode nye logon a kapipianit lo (teŋ na ɳutu logon a momorja kilo bubulö kweja geleŋ lo kilo kikolin musala logon galani Kusik ti kulya nagon lele/nene bubulö mölö i Morakindya kata).
- Nan a kurun nagon adi nan ti bulö wuju nene ŋo ropet I morakindya I ŋina ga'yu kode pipija kode I titimba.
- Nan a ruk nagon adi pipiesi na pipiari nan kune bubulö mokaji I radio.
- Nan a kurun adi kulyaesi liŋ nagon nan a tikin I na Todinet kune bubulö yakiya I to'diri.
- Nan köti a kurun adi ko lele loŋe a pukun I ŋo na rye I na todinet , nan gwon a lui. Ŋina bubulö kona ko wusa na Karen kwe, ko I tökodya na tokörет na pipiesi kwe nagon kweja tokörет nio kode tokörет na ɳutu logon nan a jambu kulya kase.
- Nan a kurun adi kulyaesi liŋ na kure kaŋo I pipiesi na pipiari nan kune bubulö 'yalaki I waraga tojo ko ŋina manini a kweya I momoret na tökörі ŋina manini kode ko na manini a wuro.
- Nan a kurun adi nya'dotesi ti kine maninijin, I kulya nagon moke I radio, ko maninijin nagon a pipiari nan kune, bubulo 'dela I pirit na'but nagon kode ɳutu lo/na ga'yu lo/na, lo meddya ka'de, tojo ko tomoret na meddya pirit duma na kendya(university) na kagala, ko tojo ko

tögwi’diesi kune köti a ruko ko tomoret duma na meddya pirit duma na kendya(university) na.

- Nan a kurun adi nan gwon ko töilien I pija kode I luŋgu na kagalanit nagon a (Allen Namazzi,) anyen kurundyo kune nyönyökesi ko kune kulya.

  Phone namba +25677697493/+256701974796

  Email: allenkatongole@gmail.com

  Nya’dotet lo/na ŋutu

  |_____perok_____

  Namba ti card |_____ Zone |_____

  Nya’dotet lo/na kagaranit |_____

  Perok_____

iii. Consent form in Arabic

aistimarat muafaqat almusharikin

aleawamil alati tuathir ealaa musharakat alsharik aldhikr fi sihat al'umi waltifl bayn aleayilat fi al'awdae al'iinsaniati. dirasat halat limukhayam IMVEPI lilajiiyna.

almuafaqat ealaa almusharakat fi albahth

• 'uwafiq ..... tawaeiat ealaa almusharakat fi hadhih aldirasat albahthiati.

• 'afham 'anah hataa law wafaqt ealaa almusharakat alan, yumkinuni alainsihab fi 'ayi waqt 'aw rafd al'iijabat ealaa 'ayi sual dun 'ayi eawaqib min 'ayi nawea.

• 'afham 'anah yumkinuni sahb 'iidhan aistikhdam albayanat min muqabalati fi ghudun 'usbueayn baed almuqabalat, wafi hadhih alhalat sayatimu hadhf almawadi.

• laqad 'awdah li algharad min aldirasat watabieatiha wa'utihat li alfursat litarh 'asyilat hawl aldirasati.

• 'afham 'ana almusharakat tatadaman muqabalatan wahidatan 'aw munaqashat majmueat altarkiz 'aw muqabalat mae almukhbirin alrayiysiiyn (sayadhakir almasharik ayan min turuq jame albayanat althalath alati syutlb minh / minha almusharakat fiha).

• 'afham 'anani lan 'astafid bishakl mubashir min almusharakat fi hadha albahthi.

• 'uwafiq ealaa tasjil almuqabalat alsawtiati.

• 'afham 'ana jamie almaelumat alati 'uqdimuha lihadhih aldirasat sayatimu altaeamul maeaha bisiriatin.

• 'afham 'ana huiati satabqaa majhulat fi 'ayi taqrir ean natayij hadha albahthi. sayatimu dhalik ean tariq taghyir aismiin wa'iikhfa' 'ayi tafasil min muqabalati walati qad takshif ean huiati 'aw huiat al'ashkhas aladhin 'atahadath eanhum.

• 'afham 'anah qad yatimu aiqtibas muqtatafat muqnieat min muqabalati fi altaqrir 'aw eard almutamar 'athna' aldifae 'aw 'iidha tama nashr alwaraqat wama 'iilaa dhalika.

• 'afham 'anah sayatimu alaihtifaz bi'ayi namadhij muafaqat mawaqaeat watasjilat sawtiat 'asliat wanuskhat min muqabili fi makan amin hayth la yatamakan siwaa albahith min alwusul 'iilaa 'an tatima almuafaqat ealaa taqrir albahth min qibal lajnat 'akhlaqiaat albahth bialjamieat wayuafiq ealaa alnatayij min qibal majlis aljamiea.

• 'afham 'ana li mutlaq alhuriyat fi alaitisal bialbahith ('alin nimazi) lilhusul ealaa mazid min al'iidahat walmaelumati. alhatif almahmul: + 256776974793/256701974796, albarid al'iiliktruni: allenkatongole@gmail.com.

tawqie almasharik / basmat al'iibham _____ altaarikh _____

ramz almushariki: _____ almantiqat _____

tawqie musaeid albayanat _____ altaarikh _____

Appendix 2

Caregiver's consent for a minor to take part the study on "Factors affecting male partner involvement in maternal and child health among families in humanitarian settings. A case study of IMVEPI refugee camp".

I…… the caregiver/community leader accept ……. A minor (below 18 years of age) to voluntarily participate in a research study on "Factors affecting male partner involvement in maternal and child health among families in humanitarian settings".

- I understand that even if I accept him/her to participate now, I can withdraw at any time or refuse her/him to answer any question without any consequences of any kind.
- I understand that I can withdraw permission to use his/her data obtained from the interview within two weeks after the interview, in which case the material will be deleted.
- I have had the purpose and nature of the study explained to me and I have had the opportunity to ask questions about the study.
- I understand that participation involves one on one interviews.
- I understand that he/she will not benefit directly from participating in this research study.
- I understand that all information he/she provide for this study will be treated with confidentiality.
- I understand that in any report on the results of this research his/her identity will remain anonymous. This will be done by changing his/her name and disguising any

details of the interview which may reveal his/her identity or the identity of the people he/she speak about.

- I understand that disguised extracts from his/her interview may be quoted in the report, conference presentation during defense, or if the paper is published etc.
- I understand that any signed consent forms, original audio recordings and a transcript of his/her interview will be retained in a secure location where only the researcher has access until the research report is approved by the university research ethics committee and results approved by the university senate.
- I understand that I am free to contact the researcher (Allen Namazzi,) to seek further clarification and information. Mobile phone: +256776974793/256701974796, email: allenkatongole@gmail.com.

☐ I give permission for this minor to be audio taped.

☐ I do not give permission for the minor to be audio taped.

By signing below, you are giving consent for your child to participate in the above study.

Caregiver's signature/thumb print _____ **Date** _____

Signature of the Data Assistant_____ **Date**_____

Assent Form

I ……..have been informed that my caregiver or community leader has accepted that I may participate in a study on "Factors affecting male partner involvement in maternal and child health among families in humanitarian settings," Although my caregiver or community leader has consented, it is not mandatory for me to participant **if I do not want**. I have been explained to the objectives of the

study and every detail pertaining to my participation. I have also been given opportunity to ask questions concerning my participation and I understand that,

- I can stop at any time I want to or refuse to answer any question and it will be okay or I will not be penalized.
- I can refuse or withdraw permission to use my data obtained from the interview within two weeks after the interview, in which case it will be deleted.
- The purpose and nature of the study has been explained to me and I have had the opportunity to ask questions about the study.
- I have been told and understand that participation involves one on one interviews.
- I am not going to directly benefit from participating in this study.
- I agree to having my interview audio recorded.
- I understand that all information I provide for this study will be treated with confidentiality.
- I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details of the interview which may reveal my identity or the identity of the people I speak about.
- I understand that disguised extracts from my interview may be quoted in the report, conference presentation during defense, or if the paper is published etc.
- I understand that any signed consent forms, original audio recordings and a transcript of my interview will be retained in a secure location where only the researcher has access until the research report is approved by the

university research ethics committee and results approved by the university senate.

- I understand that I am free to contact the researcher (Allen Namazzi,) to seek further clarification and information. Mobile phone: +256776974793/256701974796, email: allenkatongole@gmail.com.
- I consent/agree to participate in this study.

Appendix 3

3(a) Questionnaire

SECTION 1. Socio-demographic factors		
Questions	Responses	Skip to question
Zone	Zone 1 Zone 2 Zone 3 Zone 4	
101. Is the participant a Father or Mother	1. Father 2. Mother	
102. Age of male partner (answer only if the participant is a mother)	1. Below 18 years 2. 19 - 28 years 3. 29 - 38 years 4. 39 - 48 years	
103. Educational status of participant	1. Never enrolled in school 2. Did not complete primary 3. Completed primary 4. Completed secondary 5. Tertiary	
104. Educational status of male partner *(if participant is the mother)*	1. Never enrolled in school 2. Did not complete primary 3. Completed primary 4. Completed secondary 5. Tertiary	
105. Marital status	1. Legally/culturally married. 2. Cohabiting 3. Living separately 4. N/A for minors	
105. Type of marriage	1. Monogamous	

	2. Polygamous 3. N/A for minors	
107. Occupation of male partner	1. Not employed 2. Partially employed (volunteer) 3. Fully employed 4. Self employed 5. Other(specify)	
107. b) if other is selected above, please specify		

SECTION 2 Questions related to Availability, Engagement and Responsibility		
Questions	Responses	Skip to question
Before childbirth. 201. Was the father present during the pregnancy test?	1. Yes 2. No	
202. How many antenatal visits did the father accompany his wife for the youngest child?	1. None 2. 1-2 3. 3-4 4. More than 4	
203. How many antenatal education classes did the father attend?	1. None 2. 1-2 3. 3-4 4. More than 4	
204. If not, did the father make an effort to follow up antenatal clinic recommendations?	1. Yes 2. No	
205. Who was the birth attendant during the birth of your youngest child?	1. Father 2. Friend 3. Sister 4. Brother 5. Other	If father, skip 205.b
205.b) if other, specify		
206. Was the father present in the health facility during childbirth?	1. Yes 2. No	
207. In what ways did the male partner support his wife during pregnancy? *Tick all applicable*	1. Arranging transport to hospital. 2. Remind the wife about antenatal clinics. 3. Remind the wife about advice by health workers.	

	4. Ensured adequate rest during pregnancy. 5. Ensured proper nutrition during pregnancy. 6. Supported with home chores. 7. Supported with care of other children. 8. Finding information about pregnancy and birth. 9. Financial support 10. Other, specify… 11. No support received	
208. At what stage(s) of childbirth was the father involved in decision-making? *Tick all applicable*	1. Decision to get pregnant. 2. Decision to start antenatal care. 3. Decision on where to give birth. 4. Decision on birth options. 5. Decision on pain management during pregnancy. 6. Choice of birth attendant. 7. Infant feeding option. 8. Other, specify… 9. Never involved	
After childbirth 209. Did the father spend time with their newborn child?	1. Yes 2. No	
210. In what ways was the father involved with newborn baby care?	1. Changing nappies 2. Helping when the baby cries. 3. Playing with baby 4. Washing baby 5. Accompanied partner for child immunization. 6. If other, specify…. 7. Never involved	
210.b) Enter other Father's involvement with newborn baby care here.		

211. In what ways was the father involved with care for the mother during childbirth?	1. Help with bathing. 2. Preparing meals 3. Remind mother on health worker's recommendations. 4. Never 5. If other, specify….	
211. b) Other father's involvement with care for the mother.		
212. Does the family have older children?	1. Yes 2. No	If no skip to 215
213. Who took care of the children during the birth of the youngest child?	1. Father 2. Sister 3. Brother 4. Other	If not the father, skip to 215
213.b) if other, please specify		
214. In what ways was the father involved with care of older children during the birth of the youngest child?	1. Preparing foods 2. Cleaning of their cloths and their body 3. Other (specify)_____	
214.b) other ways the father was involved with care of older children during the birth of the youngest child.		
215. Is the father spending more time with the family since the birth of the youngest child?	1. Yes 2. No	
216. Average time spent by a father with the children per week.	1. Less than 4 hours a week 2. 5-9 hours a week 3. 10-14 hours a week 4. More than 15 hours a week 5. Never	
217. At what age of the children is the father more involved?	1. Before birth 2. Birth to 2 months 3. 3 to 6 months 4. 7 months and above 5. Never	
218. In which ways is the father involved with children? *Give more than one response*		

SECTION 3 Factors affecting Male Partner Involvement.		
Questions	Responses	
301. In your opinion, has a humanitarian setting affected male partner involvement? If yes, how?		
302. Which conditions in a refugee camp favor the involvement of fathers in the life of his children and wife? *Give more than one response*		
303. In a humanitarian setting, what hinders male partners from being involved in maternal and newborn care? *Give more than one response*		

3(b) Interview Schedule (FGDs and KIIs with community members)

Factors affecting male partner involvement.
101. What is male partner involvement in the context of a humanitarian setting?
102. How is this compared to male involvement in your country of origin?
103. How are male caregivers involved in maternal and newborn health?
104. In your opinion, has a humanitarian setting affected male partner involvement? If yes, how?
105. What factors have facilitated male partner involvement in a humanitarian setting?
106. What hinders male partners from being involved in maternal and newborn care?

3 (c) INTERVIEW SCHEDULE (KIIs with Health workers)

1. In your opinion, what is meant by male partner involvement in MCH in the context of a humanitarian setting?

2. How is the perception of male partner involvement different in a humanitarian setting from a normal home setting?

3. In which ways are male caregivers involved in maternal and newborn health in Imvepi refugee camp?

4. In your opinion, does living in a humanitarian setting influence male partner involvement? If yes, how?

5. On average, what proportion of male partners participate in prenatal care visits and childbirth?
   i. 0% - 5%
   ii. 6% - 10%
   iii. 11%- 15%
   iv. 16%- 20%
   v. More than 20%
6. What factors facilitate male partner involvement in a humanitarian setting? ***Give more than one response***.

7. What hinders male partners from being involved in maternal and newborn care? ***Give more than one response***.

8. How would you describe male partner involvement in maternal and newborn health in Imvepi refugee camp?

9. How else are male partners in Imvepi refugee camp involved in maternal and newborn health?

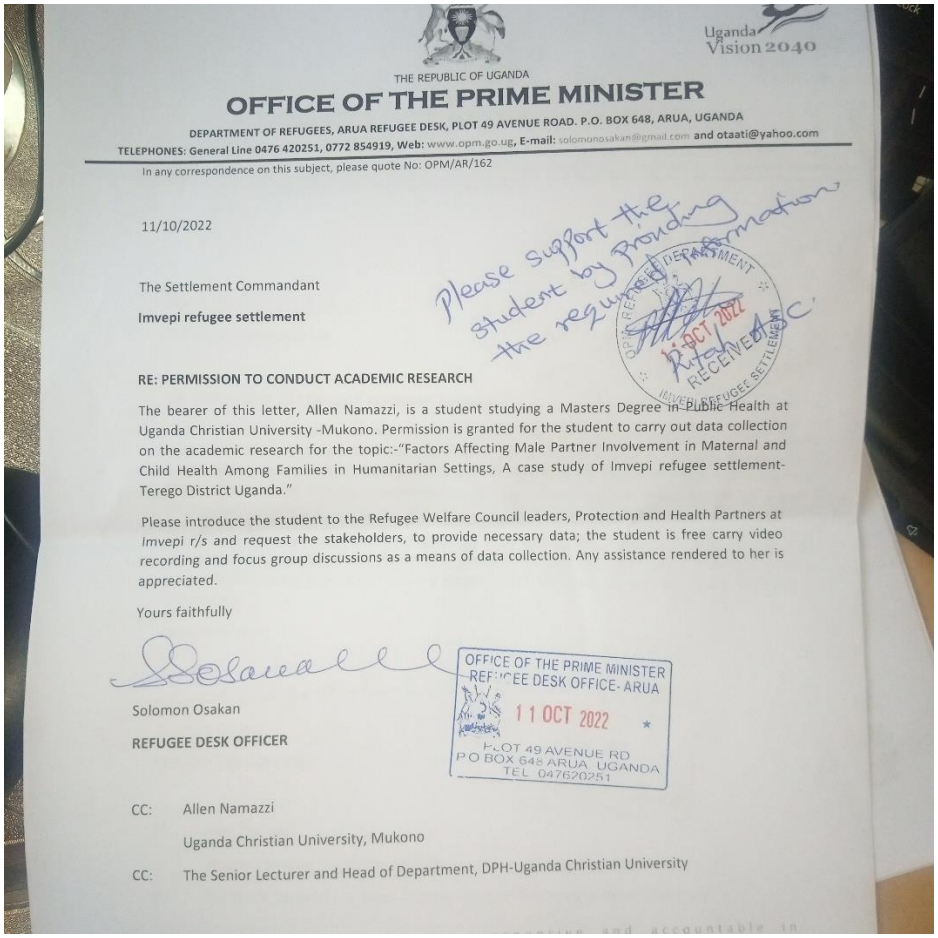
10. What should be done to improve male partner involvement in Imvepi camp?

11. Are there any other issues of particular concern to you?

Appendix 4: Gantt Chart

Activity	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
Finalize with proposal writing												
Submit porposal to REC												
Review proposal following REC												
Resubmit proposal for approval by REC												
Training Research Assistants												
Pre Testing of data collection tools												
Reviewing Data collection tools after pretest												
Data collection												
Transcribing												
Data Analysis												
Report writing												
Report submission												
Defence												
Review report and submit final copy												

Appendix 5: Letter of Approval from PMO



Uganda Vision 2040

THE REPUBLIC OF UGANDA

OFFICE OF THE PRIME MINISTER

DEPARTMENT OF REFUGEES, ARUA REFUGEE DESK, PLOT 49 AVENUE ROAD. P.O. BOX 648, ARUA, UGANDA

TELEPHONES: General Line 0476 420251, 0772 854919, Web: www.opm.go.ug, E-mail: solomonosakan@gmail.com and otaati@yahoo.com

In any correspondence on this subject, please quote No: OPM/AR/162

11/10/2022

The Settlement Commandant

Imvepi refugee settlement

Please support the student by providing the requested information

RECEIVED 11 OCT 2022 IMVEPI REFUGEE SETTLEMENT

RE: PERMISSION TO CONDUCT ACADEMIC RESEARCH

The bearer of this letter, Allen Namazzi, is a student studying a Masters Degree in Public Health at Uganda Christian University -Mukono. Permission is granted for the student to carry out data collection on the academic research for the topic:-"Factors Affecting Male Partner Involvement in Maternal and Child Health Among Families in Humanitarian Settings, A case study of Imvepi refugee settlement-Terego District Uganda."

Please introduce the student to the Refugee Welfare Council leaders, Protection and Health Partners at Imvepi r/s and request the stakeholders, to provide necessary data; the student is free carry video recording and focus group discussions as a means of data collection. Any assistance rendered to her is appreciated.

Yours faithfully

Solomon Osakan

REFUGEE DESK OFFICER

OFFICE OF THE PRIME MINISTER REFUGEE DESK OFFICE- ARUA 11 OCT 2022 PLOT 49 AVENUE RD P.O BOX 648 ARUA UGANDA TEL 047620251

CC: Allen Namazzi

Uganda Christian University, Mukono

CC: The Senior Lecturer and Head of Department, DPH-Uganda Christian University

Appendix 5: Letter of Approval from UCU REC

UCU REC approval.pdf

UGANDA CHRISTIAN UNIVERSITY

A Centre of Excellence in the Heart of Africa

UGANDA CHRISTIAN UNIVERSITY

SCHOOL OF RESEARCH & POSTGRADUATE STUDIES

DISSERTATION CORRECTION COMPLIANCE REPORT BY THE CANDIDATE (POST VIVA FORM)

Date: **27/03/2024**

Name of Candidate: **Allen Namazzi** Reg. No: **RJ21M21/018**

Title of Dissertation: **Factors Affecting Male Partner Involvement in MCH among Families in Humanitarian Settings. A case study of Imvepi refugee camp.**

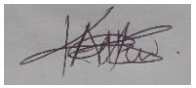
SN	COMMENTS BY EXTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1.	The face book title after the school of Public Health should be department of nursing and midwifery …… Christian university, June 2023	Department has been included.	Page i

2.	A sentence that includes …… of obstetric and newborn "danger signs among men ……" should be corrected.	This has been corrected.	Page 28
3.	The general objective should be action oriented to address the silent question which should come after "Sudanese refugees in Imvepi refugee settlement" of the general objectives that would say "and then what" The objectives are otherwise well put.	This has been rectified.	Page 7
4.	The fellow counterparts in the hypothesis should be stated so that the identity is clear.	As advised by the viva committee, a hypothesis has been replaced by a research question.	Page 7, 8
5.	The research question should be properly framed in good English.	This has been corrected	
6.	Under theoretical framework the issue of "can perform behavior" should also be rephrased properly.	This has been corrected	Page 9
7.	Minors under 18 were included but being minors they were not eligible to provide answers personally. How this issue was addressed is not clear	The researcher planned and sought consent from caregivers of minors and where a caregiver was not available, consent was sought from a community leader (RACIs). Minors were again requested for their willingness to participate using an assent form. A copy of the assent form and a consent form for a caregiver to a minor were attached under appendix 2.	Pages 14, 48 and 106

SN	COMMENTS BY INTERNAL EXAMINER	ACTION TAKEN	INDICATOR
1			
2			
3			
4			
5			

SN	COMMENTS BY VIVA VOCE PANNEL	ACTION TAKEN	INDICATOR
1.	The conclusion to be connected to the theoretical framework.	This has been worked on.	Page 91
2.	Separate the conclusion and recommendations.	Subheadings have been used to separate conclusions from the recommendations.	Page 91
3.	The theoretical framework is not aligned with the results and the other sections.	The theoretical framework is aligned with the other parts of the study e.g., in the study cultural beliefs largely referred to socio norms; perceived behavioral control clearly came out as facilitators or barriers e.g., long distances to a health facility.	
4.	Was the cultural perspective was moved in the measurement.	Yes, the cultural perspective was considered in the measurement right from designing data collection tools e.g., in South Sudan it is the role of mothers-in-law to attend to expectant women and after childbirth. The patriarchal	Pages 32, 73, 91

		nature of South Sudan communities was also studied in literate review.	
5.	The research design does not match the results.	The study design was a cross-sectional community-based survey and both the exposure (cultural background (social norms), educational level of the participant, sensitization by development partners etc.) and the outcome (male caregiver involvement) were measured at the same time.	
6.	The qualitative findings were not presented.	Qualitative findings were presented as facilitators and barriers.	Pages 69 to 70.
7.	The maintenance results were not preserved yet the title communicates that level of measurement.	Not clear.	

Allen Namazzi  **Mr. David Nangoley** 

Candidate's Name Signature Supervisor's Name Signature