

# **Women and Children First / Baylor Research Fellowship: Men's Involvement Proposal**

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## **Preface**

As we developed the following proposal, we realized that there have been a number of obstacles limiting the completeness and quality of our product. We cannot in good conscience present this as a complete, final proposal, nor can we recommend that the plan we suggest be implemented in its current state. Because of the ongoing COVID-19 pandemic, we have been unable to correspond with Women and Children First, CUAMM, or any other entity that could have given us much needed information on the Oyam District in Uganda. Since we do not know enough about the status of healthcare provision, men's attitudes, or our partner's capabilities in Oyam, the recommendations we make may not correspond to the realities in Uganda. Like the rest of the world, we are also uncertain about how COVID-19 will affect the future, specifically with regard to the situation in Oyam and the ability to implement any solution. Due to these limitations, we would like to stress that we do not expect the plans outlined in this proposal to be executed without appropriate alterations being made by those with more accurate knowledge of Oyam. With those concerns addressed, we are confident that our recommendations, based on our research, thought, discussion, and collaboration, could be effective in increasing men's involvement in MCH issues.

Throughout this proposal, we have included references to a number of the articles we consulted during our research that we found to be most helpful. These can be found at the end of this document.

## Problem

In developing countries like Uganda, men are not sufficiently involved in the healthcare of their partners and children. Low male involvement, including lower rates of clinic attendance, presents a significant challenge to maternal and newborn health. Male engagement before, during, and after childbirth can greatly improve healthcare outcomes, while insufficient male engagement worsens them (Kaye 1). Many factors contribute to low levels of male involvement in maternal and newborn health, including cultural norms and stigmas, inadequacies of the healthcare system as a whole, and the poverty of the patients. Cultural norms are likely the strongest reason that men are insufficiently involved, but unfortunately they are also the most difficult cause to meaningfully address. Because our research indicated that there were ongoing efforts to sensitize Ugandan men to the importance of male involvement, and because an intervention to effectively reshape cultural norms directly is likely outside the scope of this project, we instead decided to focus on another factor that could deter already willing men from becoming more involved.

One dimension of low male involvement is low male attendance of maternal and child health (MCH) visits with their partners. A significant contributing factor of low male attendance is the quality of care provided by healthcare workers at the clinics. Healthcare facility related causes such as these are critical to promoting male involvement in women's health issues during pregnancy and childbirth (Kaye 1). Instead of healthcare workers structuring appointments around the unique needs of their patients and treating them with respect, they provide care that is often impersonal or even abusive (Berghout, Leensvaart 1). This causes patients and their families to view these clinics negatively. This poor quality, negative care is one of the key reasons men are not actively involved in their partners pregnancy. Since men sacrifice time that could be spent working to provide for their families when attending these visits, they expect to be valued and appreciated, and for their attendance presence to be worthwhile. However, men often feel unappreciated, embarrassed, or even mistreated at these clinics, and ultimately view their presence as unnecessary. As a result of feeling unwelcome in the clinics, they do not attend antenatal appointments with their partner and are not provided with the education they need to understand the importance of their involvement in their partner's pregnancy. They decide not to go in the future and contribute to negative perceptions of these clinics. Their bad experiences stem from time wasted waiting to be seen, being forced to wait outside the clinic due to a lack of privacy for the women inside, and visits with healthcare workers who focus entirely on the pregnant woman rather than the couple as a whole.

Another healthcare facility related obstacle to male attendance is the lack of privacy within the clinics. Oftentimes, because there are no separate rooms or sufficient space dividers, men are forced to sit outside the clinic for the sake of other women's privacy while their female partner attends the appointment on her own. This is a significant wasted opportunity, as men who

do go to the effort of attending a clinic visit are denied participation at the last step, failing to receive information and education on pregnancy and what their expected role is during this time.

Male involvement in maternal and child health is crucial to achieving positive health outcomes. At minimum, men must be aware of the basic process of a pregnancy and birth so that, as head of the household, they allow the pregnant woman to receive care. The more engaged men are, the better outcomes tend to be. Higher engagement leads to more information and better understanding of MCH issues, which in turn leads to better results. Male involvement contributes to higher first trimester ANC visits, abstinence from smoking and alcohol consumption, reduction in low birth-weight infants, more birth preparations, and more PNC visits (Kaye 1). But if healthcare workers continue to mistreat patients and provide poor quality care, male attendance will likely remain low. Oftentimes, because men do not have a positive experience when they do attend the visits with their partner, they decide against attending visits in the future, leaving them uninvolved and unprepared for their partner's pregnancy, childbirth, and newborn child. Increasing male attendance at MCH visits is necessary to realize the positive effects.

Though this problem is widespread throughout developing countries, this project specifically addresses men's involvement in maternal health in the Oyam district of Uganda. While empirical data surrounding male involvement in antenatal care in the Oyam District is lacking, communities within this region have identified male involvement in MCH as an area of concern. Of course, male involvement varies by region and is affected by many factors unique to each community. Unfortunately, we were unable to find information about the situation in Oyam itself, and so our identification and understanding of the problem is based on information from other regions as similar as possible to Oyam. While we can apply some information about the issue from sources outside of Uganda, we are aware that the differences between the nature of the problem in other regions and in Oyam limits the accuracy of our understanding. Clearly, if the actual status of male attendance at MCH clinic visits or the quality of care given to patients at these visits is better than we have assumed, the context of our proposal changes dramatically.

## Solution

Our proposed intervention is to reform healthcare provision by improving the quality of the interactions between healthcare workers and their patients, removing disincentives for men to attend MCH clinic visits with their partners. By providing training in patient centered care (PCC) to healthcare workers, we hope to increase patient satisfaction with clinic visits and reduce the number of men and women who have bad experiences with healthcare center staff, thus increasing uptake of MCH services and resulting in better health outcomes.

Establishing a norm of kind, compassionate, helpful care during MCH appointments would greatly improve patient satisfaction. Healthcare workers should be trained to engage both the female patient and her male partner in discussions, providing empathetic, couple-focused communication. With healthcare provision that better engages both the female and her male partner, the patients not only receive better care, but have a higher likelihood of seeking care proactively in the future.

Implementing PCC would increase men's attendance at MCH visits by replacing the alienation men normally experience at MCH clinics with acceptance. Men in studies throughout sub-Saharan Africa have cited an overall impression during clinic visits that their presence is unappreciated as a key reason they do not attend such visits (Ditekemena et al, Kaye et al, Nayiga et al, Ongolly et al). This impression stems from being ignored by healthcare workers, and being verbally abused when not ignored. Implementing PCC would remedy this, as healthcare workers would decrease their negative treatment of their patients, including men, and begin treating them better. Eliminating the sense of hostility and unwelcomeness men experience at MCH visits is a vital step in increasing their attendance.

Another component of this intervention is the development of a program targeting men to be provided alongside MCH services at clinic visits, in order to provide positive incentives for men to attend and create a space for men within the MCH clinic experience. A common complaint from men is that they miss a whole day's work traveling to the clinic and waiting once there, only for their presence to accomplish nothing and to receive nothing in return (Ditekemena et al, Kaye et al, Ongolly et al). Providing programs for men makes male partners' presence more obviously worthwhile, establishing a clear reason to accompany their partners. These programs would provide male partners with information regarding pregnancy, childbirth, and postpartum care. The goal would be to engage and affirm men who want to be involved in their partners pregnancy during their partners MCH visits.

A very actionable possible solution to increase the quality of care would be to address problems of privacy and male exclusion where they exist by erecting basic dividers within clinics. Although certainly an imperfect method, excluding men completely from MCH clinics so severely hampers any efforts to increase men's involvement that some remedy is necessary. If men are unable to even enter MCH clinics, their decision not to attend visits with their partners is

rather understandable. Introducing dividers within clinic buildings is a simple step that could drastically increase the potential for male involvement at clinics with such privacy constraints.

We are aware that this approach to a solution may have unintended negative effects. One concern is that introducing programs targeting men may reinforce the existing patriarchal power structures that are already to blame for many problems surrounding MCH. By introducing male oriented programs in MCH settings, one of the few female centered spaces existing in the patriarchal culture could be weakened. We hope that the effect of adding male targeted programs does not compromise the female centric nature of MCH clinics, but rather creates space for men within them to facilitate male involvement.

We are also aware that this “solution” will not in fact completely solve the wicked problem of low male involvement. We know that there are many other factors contributing to low male attendance at MCH clinic visits, and that this solution does not address them all. Cultural norms of behavior and economic limitations also should be addressed in order to increase male involvement and men’s attendance at MCH visits. Our goal is to ameliorate the situation, addressing one dimension of the problem with an intervention that seems most feasible and most effective based on our understanding of the problem and possible solutions.

## Plan

Since CUAMM has an established presence in the Oyam district, we propose that this grant be used to fund the training and work of one or more CUAMM workers in the district. This worker or workers would provide training to the existing health care staff at the clinics. The training they would be presenting would be approved information from CUAMM and W&CF, because of their knowledge of the local situation and necessities. These two organizations are far more equipped and knowledgeable of Ugandan culture and society than we are, so they have better credentials to develop the details of the curriculum. Once a curriculum is developed, facilitators would need to learn the curriculum and content as well as how to teach it, and then be sent to clinics and hospitals to train healthcare workers. If a healthcare clinic has an established meeting or debriefing time, the CUAMM representative could present the training material in a presentation and discussion format during that time.

Although we cannot fully develop the curriculum ourselves, we would like to recommend that it include a number of core concepts. An article by Nayiga et al. includes a brief outline of a curriculum for an intervention very similar to the one we propose which could be a helpful starting point.<sup>1</sup> The key components of the curriculum should include respectful patient interactions, engaging with both partners present, active communication, and greater self-awareness during patient interactions. Greeting and thanking the patients, as well as being receptive to questions, are important practices to be discussed and implemented among healthcare workers. Healthcare workers should have an extra awareness of engaging the female and male in conversations when both are present. This should be done before, during, and after the checkups. This ensures that both parties are aware and informed of what is happening and what needs to happen to ensure a healthy pregnancy. As men have reported feeling unneeded in ANC appointments because they are not engaged in conversation or receiving information, engaging the male partners in discussion about the ways he can financially and emotionally support his partner leading up to, during, and after delivery can give actionable steps for the men to take. Thus, it is very important to speak to the couple as a whole.

The presentations would include an introduction of the CUAMM representative, a brief overview of the practices discussed in the presentation, the reasons for the change in behavior, and then a more in-depth explanation of the specific actions. The presentation concludes with a time for questions and discussion. If appropriate, an activity demonstrating the behavior can be conducted. If there is a need for and resources to fund multiple visits, the curriculum can be split across multiple meetings, which would be recommended. Each follow-up meeting should begin with updates from the healthcare workers.

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<sup>1</sup> Nayiga, Susan et al. "Strengthening patient-centred communication in rural Ugandan health centres: A theory-driven evaluation within a cluster randomized trial." *Evaluation (London, England : 1995)* vol. 20,4 (2014): 471-491. doi:10.1177/1356389014551484; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4425297/>.

These training sessions can be done over the course of one to three months, depending on frequency of training sessions and the availability of CUAMM resources, each of which is limited by how much activity the grant can fund. If training sessions are dispersed over a longer period of time, the individual training sessions can be conducted during existing meeting times, as mentioned earlier, or in the half hour before or after the clinic closes for the day. One of the foreseen issues with holding staff meetings before or after the clinic opens or closes is that workers will need to get to the clinic even earlier than they already do or would have to stay longer when they are already tired. The grant would be used to pay the healthcare clinic workers for this additional time.

In addition to healthcare worker training, it could be helpful to have a program for the men that are accompanying their partners to antenatal care appointments to receive information about maternal health and men's health issues. During the time the men are already waiting in the clinic, a small men's gathering could be a helpful way to share information. During these discussions, men can be informed on valuable information pertaining to maternal health, health signs and warnings, how to help postpartum, breastfeeding, follow up appointments, and the importance of going to these appointments. The material covered in these meetings should be specific and relevant for the men that are being educated. It should be obviously applicable, as to not bore the men. By having these 'men's groups,' men can feel far more involved and useful. Additionally, as these could be conducted during the time when the healthcare worker is attending to the female partner, this could address concerns about increasing throughput time because of added conversation during an antenatal care appointment. These discussions can serve as ways to build community and trust among the men and perhaps reduce the cultural stigma of discussing maternal health issues. Depending on the financial resources, staff, and space available, these could be outside the waiting area and mediated by a healthcare worker or a trained leader. The suggestion to hold these men's meetings could be made during the healthcare worker patient centered care training, alongside further information as to content, structure, and implementation.

As far as delivery options, there are three different options. One idea would be to have a travelling facilitator or small team from CUAMM reach each health clinic, providing regular, short workshops. They would present at the health care facilities designated staff meeting. Over the course of one to three months, training could be more in-depth and developed. While this could become quite costly and time consuming for the providers, we recommend this system. Another idea is to have, again, a travelling facilitator or small team reaching each clinic to provide intensive, half-day workshops. This may be easier for healthcare workers as it is a one-time event. However, this structure may sacrifice some quality of education, since there will not be opportunities for material reinforcement after the workshops. Because of less travel, this idea may be somewhat cheaper and easier for providers. The last idea would be to have a full day of intensive workshops provided by facilitators at a regional hub, such as the Aber hospital. This



## Partnership

We recommend CUAMM as the partner organization for the project. CUAMM is an Italy-based medical organization that seeks “to advocate the universal right to health and promote the values of international solidarity, justice and peace” (“Vision and Mission”). The organization focuses its work in vulnerable communities in Africa, including Uganda’s Oyam District. This work covers a wide scope of health concerns, and includes a focus on maternal health. The organization conducts research, carries out awareness campaigns, and trains or re-trains healthcare workers. Because CUAMM’s mission, expertise, and active services heavily overlap with our proposed healthcare worker training to better maternal health outcomes by seeking to increase men’s involvement in their female partner’s pregnancy, we recommend partnering with this organization.

CUAMM is already operating in Oyam. In the organization’s 2018 Annual Report, CUAMM reported continuing efforts in the Oyam district “with widespread intervention throughout the villages, health centers, and hospitals” (Doctors with Africa CUAMM). As of 2018, CUAMM had 115 workers in Uganda who support 409 health facilities. Because these efforts were at the local, area, and district level, the infrastructure and relationships needed for a training program to be effective is already established, so there are fewer barriers to implementation than an organization new to the area would face. Therefore, CUAMM’s long presence in the Oyam District, their active programs, and their worker, information, and relationship infrastructure make this organization a strong potential partner for this project.

Our work is in line with Women and Children First’s mission because we are striving to improve maternal health outcomes by increasing male support. By increasing male involvement, women should have a lower risk of life threatening complications before, during, or after childbirth. When men accompany women to antenatal checkups at health clinics, the men become more aware of what is needed, fostering a better understanding of what their female partner is experiencing and where she may need additional support. Women and Children First strives to partner with the members of communities by supporting self-organized projects that help women and children flourish. Our emphasis on improving healthcare facility patient relations through staff training aligns with these efforts. Our work seeks to create a culture with stronger support of women, and we have hopes that in the long run, social barriers that are faced by both women and men will be broken down.

## Budget

This plan does not rely on providing much material goods, but it is quite time and labor intensive. Curriculum development must be financed, the training facilitator(s) must themselves be trained, the healthcare worker training process must be rolled out, and it must be evaluated, all of which require funds. We are severely limited in our ability to determine the costs of the many necessary components of this intervention. However, below we have tried to itemize the projected needs as much as possible. Costs that vary depending on the program delivery timeline are listed based on a program such as presented in the Gantt chart above where the training provider visits each clinic multiple times for short training systems.

### Healthcare Worker PCC Training:

#### Curriculum Development Costs:

- Depending on the expertise of the individual, development could require 1-3 days of work. Costs: 1-3 days of wages.
- Alternatively, this could be done as contract work at a lump sum price.

#### Personnel Costs:

- Wages for time used to identify or recruit an individual to provide training
- Pay for the training of the healthcare worker training facilitator (wages, transportation, wages for the person who is conveying the training information)
- Transportation, lodging, and wages for training worker
- Paying healthcare clinic workers for training time
  - This depends on the healthcare worker's workday hours and length of training session. As we want to honor the healthcare worker's time, if it is financially feasible, we would like to compensate the healthcare workers at a higher rate than their typical wages. As an example, the wages could be calculated as follows:

$$\text{Compensation} = \frac{\text{hours of training}}{\text{hours in typical workday} - 1} \times \text{typical daily wages}$$

**OR**

$$\text{Compensation} = 1.1 \times \left( \frac{\text{hours of training}}{\text{hours in typical workday}} \times \text{typical daily wages} \right)$$

#### Training Material Costs:

- Copies of curriculum material (agenda, readings, etc.)
- Printer, if not accessible
- Paper, if needed for printer
- Ink, if needed for printer

#### Evaluation Costs:

- Printed paper for evaluation forms
- Writing utensils for completing evaluation forms

- Clipboards to write evaluation on, if needed
- OR** (see “Significance” section for explanation)
- Survey chip receptacle for each clinic
- Survey Chips for each clinic

### **MCH Clinic Men’s Meetings**

#### Curriculum Development Costs:

- Depending on the expertise of the individual, development could require 1-3 days of work. Costs: 1-3 days of wages.
- Alternatively, this could be done as contract work at a lump sum price.

#### Personnel Costs:

- Ideally, the meetings are held in existing space in or near the clinic, so this aspect should not require additional funding
- Existing healthcare worker workloads may require the hiring of additional staff to free a worker to run the meetings.

The sustainability of this plan must also be considered. On the strictly financial interpretation of sustainability, the healthcare worker training part of this plan is highly sustainable, as its primary component is a one-time intervention rather than a perpetual service or program that requires continued support. The establishment of men’s meetings at MCH clinics does involve an ongoing program, but we hope that the costs of running these meetings is minimal. Financially and materially, this plan is sustainable since it is free of any long term significant resource demands.

It is also worth considering the lasting impact of this plan, the sustainability of its effects. That will depend heavily on how the training is received. Ideally, this training is helpful, enabling healthcare workers to improve the quality of the care they provide as they put PCC into practice. In this scenario, it is not unreasonable to think that the effects of this intervention could continue for years. However, it is also possible that healthcare workers in some clinics are so weighed down by excessive workloads, insufficient supplies, and paltry earnings that they are unable to successfully implement PCC initially or maintain its implementation in the future. Given that addressing those problems would be unsustainable with our currently available resources, seeking to train healthcare workers in PCC remains the most promising approach despite those concerns.

# Significance

## GOALS

Increase male involvement and investment in maternal health through creating a welcoming and more respectful healthcare environment.

Create a culture of respect and dialogue between patients and healthcare workers

## OUTCOMES

Higher levels of patient satisfaction from healthcare clinic visits

Reduced instances of men feeling shunned, disrespected, or ignored when attending antenatal care appointments with their female partners

## OUTPUTS

Higher levels of men attending antenatal care appointments

Reduced word-of-mouth spread of negative healthcare clinic experiences

Reduced stigma of men being involved in their female partner's maternal health.

## EVALUATION

The most direct way to evaluate effectiveness of this program would be through exit surveys for patients attending the clinic. Data should be gathered on sex, whether the individual or their partner is pregnant, whether they felt like the clinic staff was friendly, whether they felt respected, whether they were engaged in making a decision, and whether they plan to return to the clinic for the next routine check-up.

The main constraint on this surveying is literacy, material, and data retrieval.

If a patient is unable to read, they will require assistance completing a written survey, which decreases the likelihood of an unbiased survey being conducted. As women and poorer populations have higher rates of illiteracy, this has the potential of strongly skewing the data.

If a written survey were to be conducted, the survey would need to be printed and delivered to the clinic. The transport could be done by the CUAMM partner when they go to the clinic to give training. As we are unsure how expensive printing is in the Oyam district, this could be a budgetary constraint.

A third concern is data retrieval. If a CUAMM partner is able to visit a clinic multiple times for different stages of training, they can retrieve the completed surveys upon arrival. However, these surveys will have to be securely collected and stored, which could be problematic, especially if there is any incentive system put in place for the healthcare workers.

Alternatives to written surveys are systems such as the Happy-or-Not feedback kiosks that are often seen in stores, restrooms, and customer service areas. There is a single question, such as "Are you satisfied with your visit today?" with response options showing a happy face, a neutral face, or a sad face. While the Happy-or-Not kiosks in particular should not be installed in

clinics due to technological and budgetary constraints, the general idea could be adapted to the clinic, where a written question can be answered with small objects, such as chips, marbles, or small stones being dropped into happy, neutral, or sad response receptacle. Again, answer security is a concern here, as is answer confidentiality. This single-question format can give very limited data on patient opinion, and does not collect data on sex, age, pregnancy status, and other key data points. Different chips could be used for males and females, but this complicates the response process. Lastly, literacy is again a constraint as this system would likely rely on a written question.

### SCALE

If successful, the healthcare worker training is highly scalable as it relies on distributing an intangible asset. The limitations would be training partner availability and financial support, building trust with new communities, language barriers, continuing evaluation processes, and the need to adjust training to specific cultural norms surrounding the healthcare worker-patient relationship.

As CUAMM operates established programs in many regions and countries, it could be a continued partner when scaling this program.

### INFLUENCE ON BENEFICIARIES AND OYAM COMMUNITY

While the primary activities of this program directly involve and impact the healthcare workers, we hope that better patient interactions increase the trust in and value of healthcare in general and antenatal care in particular for individuals in the Oyam district. With higher levels of trust and value, we hope there is a widespread fuller understanding of the male's role in maternal health, leading to higher levels of support for women, and better and safer antenatal and postnatal outcomes. Safer pregnancies lead to fewer deaths, healthier children, and a more stable community.

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