

Factors affecting Male Involvement in Antenatal Care in Kafue Ward of Chililabombwe District

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ABSTRACT

Worldwide, every pregnancy faces a component of risk. Men, as partners and decision-makers, need to be involved in maternal health services. Men accompanying their wives in routine antenatal care (ANC) and other maternal health services is very important towards contributing to the reduction of maternal morbidity and mortality. It also presents an opportunity for the health personnel to teach them on the importance of an obstetric emergency early to so on form appropriate decisions and actions which will influence the results of the pregnancy. However, very few men are fully involved in ANC due to various reasons and situations. This study, therefore, investigated the factor that affect male involvement in ANC in Kafue Ward of Chililabombwe District. The study employed a survey research design using stratified random sampling collected data employing a questionnaire from 58 men and 23 women. The data was analyzed, processed using the SPSS version16.0, and presented in pie charts. The findings of the study indicated that although men had a high level of data on ANC only a few accompanied their wives/spouses to the clinic, still had very poor attitudes towards ANC because most of the programmes at the clinic were designed for ladies only and therefore the work schedule prevented most men from attending ANC services. The study recommended having ANC service programmes that might include men to completely participate in ANC services.

Keywords— Male involvement, Antenatal Care.

1 INTRODUCTION

Maternal mortality has been spreading globally at an alarming rate. The World Health Organization (WHO) reported that 289,000 women died from pregnancy and childbirth complications per annum, with 99% of the 800 women who die daily occurring in developing countries (WHO, 2015). Maternal mortality ratios also are very high in developing countries as compared to developed countries. In developing countries, the ratios are 240 per 100,000 births while in developed countries the ratios are 16 per 100 000 births. These quite disparities also are found within countries among people of high- and low-income status groups. These ratios also very high in rural and peri urban areas of the many developing countries where poverty, social norms and traditions are seen as a serious contributing factor (WHO, 2014).

In Zambia, a significant and huge burden of women's pathological state within the childbearing group is due to pregnancy and childbirth related complications. These women are within the productive age bracket of 15 to 49 years. It's estimated that 398 women once a year die from pregnancy related complications out of each 100,000 live births. The risk of a woman dying from a pregnancy related complication is 1: 20. This suggests that a pregnant woman in Zambia features a twenty times chance of developing and dying from pregnancy related complication. Over one-half of those maternal deaths are attributed to direct causes of postpartum hemorrhages, sepsis, obstructed labour, abortion, and eclampsia. Majority of those women who die from pregnancy related complications die either reception or on their due to the hospital. The foremost important contributor to the present high number of maternal deaths is that the delay when making an option to seek maternal and obstetrical care at both household and community levels. This delay by women to seek medical and obstetrical care even in an occasion of pregnancy complications is claimed to

be due to lack of advance planning and preparation for childbirth on an area of the expectant family (MOH, 2010).

Therefore, improving maternal health is included within the third goal of the United Nations Sustainable Development Goals (SDG) framework, to which Zambia subscribes (Rosa, 2017). Furthermore, maternal health is additionally highlighted as a primary focus within the UN Global Strategy for Women's, Children's and Adolescents' Health (WHO, 2015). During the period between 1990 and 2013, Zambia's annual rate of decline in maternal deaths was 0.56%. At its current rate, Zambia isn't on track to achieve the third SDG's goal of a maternal mortality ratio of but 70 maternal deaths per 100,000 live births by 2030 (Rosa, 2017).

Maternal health care is therefore, plays a vital within the reduction of the high number of mortalities and involves the participation of both men and women. However, this is often a serious challenge as reported by WHO (2012) who noted that a lot of the reproductive health programmes and services mainly specialize in women leaving out the men. Sternberg and Hubley, (2004) in their study noted that the consequence of this was that men therefore, lacked major information and their ability to make informed decisions about healthy behaviours and what roles they were expected to play in the promotion of the overall family health that included to the relevant information on Human Immuno-deficiency Virus (HIV) prevention and the care and treatment provided. The reason for this was to encourage the men to fully participate in all sexual reproductive issues to help improve the overall health of their families. Jennings et al, (2014) and Kalulanga et al, (2012) explained that concept of male partner participation in sexual and reproductive health were important and being advocated for in ensuring that the elements of the WHO initiatives would help improve maternal care that would result in safer pregnancies. This would

also help in the reduction of maternal and infant mortality rates.

Male involvement is considered a major driving force of maternal mortality reduction. Therefore, the participation of men according to recommendation from previous literature requires them to be very active in sharing the responsibility on maternal health as a measure that help improve maternal outcomes (WHO, 2015). However, despite the recommendation from previous literature on the active participation of men in maternal health, there is still a wide gap between the male involvement policy and the actual involvement in pregnancy and birth (Kaye et al., 2014).

There have been various definitions of male involvement in maternal care such as that of Kalulanga et al, (2012) citing the (United Nations (UN), 2009), described male involvement in maternal health care as a process of social and behavioral change that requires men to be more proactive and responsible in maternal health care of ensuring the wellbeing of women and children. Mukobi (2012) on the other hand in his definition was more focused on male participation in Prevention of Mother to Child Transmission (PMTCT) of HIV were men accompanied their spouses, provision of social economic support and using family planning in child birth control and also the HIV prevention measures.

A clearly definition on male participation in maternal and child health care is provided for by Bhatta (2013) who explains that it is a process were men attend antenatal health care visits, birth planning, whilst encouraging exclusive breast feeding and immunization for the children. The male partner or husband is meant to accompany the wife or female partner to the Antenatal Care (ANC) by providing the social economic support and ensuring all the recommendations that are made at

the ANC are observed so that the couple and the baby are safeguarded.

In African countries, men play a central role in decision-making within a home and are often the breadwinners. Therefore, establishing their participation and support for PMTCT of HIV especially and sexual reproductive health as an entire is critical (Ditekemena et al., 2012; Nakambo, 2008; Mullick et al., 2005; Mungaila, 2007). Bhatta (2013) observed that male participation enables men to support their spouses to utilize obstetric services and therefore the couple would adequately brace oneself for birth complications. This is able to reduce altogether three phases of delay. Delay in making the choice to hunt care; delay in reaching care; and eventually, delay in receiving care in times of emergency (Kaye, 2014; Bhatta, 2013).

In the last decade, attention to the role of men in reproductive health has drastically increased. It's now widely known that men are key agents where a decent range of sexual and reproductive health practices are concerned (Bruijn, 2004). Literature has shown that healthy outcome of pregnant women and their new born, whether positive or negative are determined largely by decisions made by the woman's partner and therefore the family and within the household. Increased involvement by men in fatherhood can benefit men, also as women and children, within the type of higher health. For example, men can give both psychological and emotional support to the woman during pregnancy and delivery. This, in turn, can reduce pain, panic and exhaustion during delivery (WHO, 2010). Men's involvement in maternal and child health programmes can reduce maternal and child mortality during pregnancy and labour by being prepared for instance, for obstetric emergencies. The increased involvement in fatherhood can also benefit men's own health and wellbeing. As an example, men who are recognized in their new position as fathers and experienced emotional

support during the pregnancy have better physical and psychological state. Ntabona (2001), gives an assumption that for all the steps leading to maternal survival defined within the mother- baby package, there's always an individual standing by the side of every woman knocking at the gate before during and after each pregnancy.

The WHO recommended in 2015 on maternal and newborn health promotion interventions had to include the complete involvement of men during pregnancy, child birth and post natal care period as an efficient intervention for the development of maternal care. However, the autonomy of women to making their own decisions must be respected in order male involvement to be successful (Davis et al., 2012).

2 LITERATURE REVIEW

2.1 Level of Knowledge of Male Spouses on Antenatal Care

The key elements of the birth plan package include recognition of danger signs, thought for a birth attendant, a thought for the place of delivery, and saving money for transport or other costs just in case the need arises. Additionally, for birth preparedness, a possible donor and a decision-maker (in case of emergencies) need to be identified. This is often actually because complications like hemorrhage are unpredictable and fatal if timely treatment isn't obtained. It is important to have interventions in Antenatal Care Clinics usually include the identification and management of obstetric complications like pre-eclampsia, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy (IPTp), and identification and management of Infections including sexually transmitted infections such as HIV and syphilis. Women and their male spouses who attend ANC also likely to find an opportunity to learn more on the promotion and the use of skilled attendance at

birth and healthy behavior like breastfeeding, early postnatal care and planning for optimal pregnancy spacing (Gathuto, 2014).

The lack of knowledge has however, has made these obstetric complications difficult to predict as found during a cross sectional survey that was conducted by Mersha (2018). The survey included 824 men mostly within the agricultural region of Northwest Ethiopia where it had been found that that that they had a scarcity of basic knowledge about the danger signs within the perinatal period and preparation for birth. Only 49% of the lads could identify one danger sign during pregnancy, they named high fever most frequently, then abdominal pain, then vaginal bleeding. Fewer than 33% were able to name a logo during labour, they identified vaginal bleeding and prolonged labour. 26% named a danger sign after birth, which was vaginal bleeding. Out of the six birth preparations steps, only 11% knew three or more. 31% did not know any and 44% knew just one. In concluding the study, Mersha (2018) reported that men who had a university education, and were married and lived in urban areas were more likely to possess more knowledge than people who did not.

In another study conducted in Malawi showed that knowledge of pregnancy complications among male partners also varies by residence. Consistent with the findings of this study, ignorance of signs of pregnancy complications is surprisingly high among fathers in urban areas which stood at 72%, although they tend to be better educated and have better access to information than their counterparts in the rural areas at 63%. Generally, knowledge of pregnancy complications among men within the most urbanized districts of Malawi is restricted. Few men in Blantyre and Lilongwe know about high fever, and only 3% realize prolonged labour. Knowledge of pregnancy complications is far higher in less urbanized district like Thyolo and Mulanje districts. (National Statistical Office, 2005).

Similarly, in a study done by Mweemba (2015) in Kabwe district of Zambia using both qualitative and quantitative methods that involved interviewing 210 respondents from both the urban and rural it had been revealed that respondents from Kabwe urban were more knowledgeable on ANC services though with a minimal difference (93.9%) as compared to the respondents from Chamuka rural areas (92%). within the study, it had been also revealed that respondents from urban areas had more knowledge of PNC services (96.2%), slightly above their counterparts within the rural areas (89.2%). However, the analysis of the findings showed that men from rural areas were more involved in maternal health services (85.7%) as compared to the extent of male involvement in maternal health services in urban areas (72.4%). The study also revealed that men were more included in ANC than PNC services.

From the study by Mweemba (2015), it is important to understand that the level of knowledge among men also varies between those that are in urban and rural areas.

The lack of proper knowledge on ANC among husbands was also an important factor because even the postnatal period would also be greatly affected as observed by Nayana (2015). The husbands' lack of proper knowledge regarding maternal and childcare, and their health care participation was found to be declining from the time of pregnancy to child immunization. Myths and misconceptions regarding immunization exist among husbands. This could be resolved by involving husbands in maternal and child health care from antenatal care onwards. It sounded the need for strengthening policies that ensures husbands participation in maternal and child health care.

Despite the low percentages of male involvement in ANC there have been a variety of issues motivated men to attend antenatal care with their spouses, among them were knowledge on the importance of

attending antenatal care, the will to understand their HIV status, commitment or love between the couple, and good communication between the couple. According to World Health Organizations (WHO, 2007), the Partnership for Maternal, Newborn and Child Health (PMNCH) reports showed that in Swaziland, HIV prevalence among pregnant women attending ANC arose from 4% in 1992 to 43% in 2004 which each 11 day, 1800 children worldwide become infected with HIV, the overwhelming majority of them newborns. Therefore, during this regard, PMNCH works to take a position, deliver and advance to save lots of lives of girls and young children with HIV/AIDS. To achieve of these fundamental goals effectively and quickly, investing within the education and involvement of men during/after pregnancy and in programs for mothers living with HIV/AIDS is extremely crucial. Moreover, there's got to advance the engagement of men within the ANC as PMTCT efforts may fail without their support. "When men test, adherence to PMTCT may increase" (Msuya et al. 2008). One study has demonstrated a discount in HIV-associated infant death rate and poor feeding options (Aluisio et al. 2011). Male-partner involvement can also lower transmission risk to sexual partners, which has been shown to be greatest within established partnerships (Dunkle et al. 2008).

2.2 Attitudes of the men towards antenatal

Changing men's attitudes is vital to achieving better outcomes in maternal and child health; knowledge and education alone might not be enough. for instance, interviews conducted among the Hausa people in Northern Nigeria showed that the majority men were conscious of contraceptive methods (nearly two-thirds reported knowing a minimum of one method), but 85% of men weren't willing to permit their spouses to use birth control, even once they weren't able financially to require care of their current number of children (Duze and Mohammed 2006). In the interviews, men reported

that the explanations for his or her negative attitudes toward using contraceptives were that their religion discourages the utilization of contraceptives to stop childbearing which a child's birth is amid wealth, so it's desirable to have many children (Duze and Mohammed 2006). Negative attitudes of men that the majority of the health providers within the health facilities are women, hinder their involvement in maternal health services. In most of the maternity wards in Zambia, there are notices on the entrances which prohibit men from entering the wards and this results in low male involvement in maternal health services because maternity wards are treated to be for pregnant women who are in labour. The normal practice of young women getting to their natal homes for maternity discourages male participation in health issues. There's a robust belief during this society that a person isn't alleged to witness the birth of the child if he does so he can lose that strength (Mweemba, 2015). Reporting the findings within the study done in South Africa by Mullick (2005) revealed that some health care workers are such a lot attached to the thought that maternal health service is for ladies such as don't have an initiative to involve husbands within the care of their wives. This was done through a baseline survey that included 2,082 women of which 1,087 were a part of the control group whilst 995 were for the intervention. The male partners of the women within the intervention group were interviewed and a structured questionnaire was used. A follow-up rate of 68% was achieved for the ladies and 80% of their partners were interviewed in both the control and intervention sites.

Studies showed that men didn't attend antenatal clinic because it had been not their role as prescribed in social norms. Pregnancy and services provided during antenatal health care were a women's affair (Kalembo et al., 2012; Clark, 2012). Socio-cultural definitions of masculinity made it difficult for men to hunt reproductive health

information or services (Abass et al., 2012). Larsson et al. (2010) noted that the norm that men shouldn't show weakness, for instance, by seeking health care, dictated against men testing for HIV, especially alongside their wives during antenatal health care. They also offer resistance to women's efforts to influence them, including problems with HIV-testing. This was typical of the facility structures related to the patriarchal relationship between males and females (Clark, 2012). The community's attitude towards a person who accompanied his wife to antenatal health care was negative. Men who accompany their wives to antenatal health care services were seemed to be dominated by their wives (Nkuoh et al., 2010). As a consequence, the vast majority avoided attending antenatal health care with their wives thanks to negative stereotypes.

In many societies that embrace patriarchal social norms, beliefs and culture, male partner does not generally accompany their partners to antenatal or postnatal care services and are never expected to be present during the birth of their children (Chattopadhyay, 2012; Kwambai et al., 2013). Furthermore, the lack of information as regards to maternal care services is a significant factor that continues to impede male active participation, hence the need for more education and awareness campaigns (Sharma et al., 2018).

Ditekemena et al. (2012) and Byamugisha et al. (2010) observed in studies conducted in Uganda that, some men's occupations negatively influenced the male participation within the antenatal PMTCT programme. This study explored how employment within the military influenced male participation in antenatal health care. HIV infection was observed to be highly related to stigma in many societies. The very fact that ANC was linked to HIV testing for the attending couple made some men have second thoughts about participating in it with their wives or partners for fear of individuals going to know their HIV status and stigmatizing them. This

compounded the assumption by majority of the men that HIV testing was compulsory during ANC (Auvinen et al., 2013; Kalembo et al., 2012; Larsson et al., 2010). Larsson et al. (2010) further observed that lack of integration of HIV care and other health services exposed beneficiaries' HIV status and thus increased the matter of stigma. They noted that men began to notice clients' HIV status due to the precise days they are going for a checkup and specific areas of the clinic they visited. Some men were very sensitive and would therefore avoid being tested at the least cost. They might therefore stand back from ANC which they believed made HIV testing mandatory.

The fear of receiving a HIV positive result and confidentiality concerns prevent some men from coming for ANC. In many studies men were mentioned worrying about HIV-associated stigma and disclosure. Men could also be scared of HIV status disclosure during a health system facility, within the context of weak health system. In another study, women said that engaging their partners in PMTCT would be particularly challenging if men were unaware of their status, refused to be tested, or were in denial about their HIV status (Reece et al. 2010). There also seems to be a niche in knowledge associated with discordancy. Some men questioned the necessity for testing if their partners had already been tested, believing that they might have an equivalent test results as their partners (Falnes et al. 2011). Men also feared discordancy due to the anger and bitterness it could cause within the relationship.

Some men were discouraged from attending antenatal health care with their wives or partners thanks to the tough behaviour of some medical personnel. Men felt unwelcomed and disrespected during antenatal health care. In some cases, the doctors mistreated pregnant women and this made men feel uncomfortable and embarrassed leading to them having negative attitudes and didn't wish to accompany their spouses again (Auvinen et al.,

2013; Byamugisha et al., 2010; Ditekemena et al., 2012; Larsson et al., 2010). Thanks to this embarrassment, the prospects of men returning for antenatal health care in future diminished. Theuring et al., (2009) noted some barriers that influenced the attitudes of men. In trying to understand the male attitudes regarding partner involvement into ANC/PMTCT services in Mbeya Region, Tanzania, a study was conducted involving 124 individual interviews and 6 focus group discussions. Most respondents generally supported PMTCT interventions. The negative attitudes of men, in reference to ANC/PMTCT that were mentioned included poor attendance, lacking information/knowledge, no time, neglected importance, the services representing a female responsibility, or fear of HIV-test results. Only few perceived couple HIV counselling/testing as disadvantageous. Among fathers who had refused previous ANC/PMTCT attendance, most had done so albeit they weren't perceiving an obstacle about couple counselling/testing. The contrast between men's beneficial attitudes towards their involvement and low participation rates suggests that external barriers play a serious role during this decision-making process which partner's needs should be more specifically addressed in ANC/PMTCT services. Nakambo (2008) in a study done in Kafue district notes that generally, the men seemed to have this idea that the health service providers at the health facilities would rebuke them, especially if they were seemed to not have adequately cared for his or her spouses.

2.3 Factors Affecting Male Involvement in Antenatal Care

There are various factors that affect male involvement within the antenatal care (ANC). These factors clearly go against prevailing gender norms in many places in Sub-Saharan Africa (SSA).

Reproductive health was seen by men as “women’s work”. Men saw the antenatal clinic as women’s space, and therefore the definition and organization of the program as fundamentally female oriented (Reece, et al. 2010). According to Byamugisha, et al. (2010), there are various factors which are identified in other studies as barriers to male involvement within the ANC and that they include: Health-facility factors, Cultural factors and Socio-Economic factors. The failure to include men in maternal health promotion, prevention and care programs by policy makers, program planners and implementers of maternal health services has had a significant impact on the health of girls, and therefore the success of programs (Greene, et al. 2002).

Male involvement is affected by cultural values. Cultural values are said to be hereditary and sort of the core of the culture these include customs, ritual conventions, styles, and fashions that remain in the core culture for example of such are respect for the elders and ladies, kindness, telling the reality than on. Many cultures, especially in Africa, regard pregnancy and delivery as a female domain; therefore, men are often not expected to accompany their wives to the antenatal care (ANC) clinic or be present during delivery (Robab, et al., 2015). To carefully not there are some of these harmful traditional practices include; gavage of women; early marriage; the varied taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices. The importance of cultural values is that it plays an excellent role in shaping the men and take an active role in engaging their women from the primary day of conception till birth and therefore the attributes of cultural values are segregation of gender roles communication between spouses, beliefs/taboo and polygamy (WHO 2007).

The negative cultural believes, social pressure and an excessive amount of submission to the elderly can influence male involvement in antenatal care. A

study in birth control indicated that there was a positive relationship between young men subjective norms and their intentions to debate birth control (Masters et al., 2017). This means that when subjective norms increase, young men intention to debate birth control also increases. There other researchers who also established that there's a big effect of cultural norms and male involvement in maternal health (Idowu, 2013).

Some men felt their obligation was to facilitate their wives in terms of transport and if they did not have means of transport, they see no point in escorting them while both of them were walking. Thaddeus and Maine (1994) illuminated that long distance to a clinic is one among the most important determinants within the decision to not seek modern health care even when needed. Yet in many situations in Zambia where the person is economically in position to supply the basic necessities of life, he tends to possess quite one wife, which also negatively affects his willingness and skill to escort the wife to hunt care (Example, amongst the Tongas of Southern Province and the Mambwes of the Muchinga Province of Zambia). Multiple partner relationships promote different interests for the person and his partners and this may hamper possibilities for transparent in deciding in health-related issues. Reporting his findings, Nyane (2007) citing (Ratcliffe, 2001) noted that men are often involved in multiple sexual relationships that present a substantial challenge to fertility awareness and reproductive health programmes.

Distance and geographical challenges reduced male partner participation in ANC activities (Auvinen et al., 2013; Byamugisha et al., 2010; Ditekemena et al., 2012). This is often because distance brought on board the necessity for finances to satisfy transport costs that might not be readily available to some families. Distance was also related to opportunity costs. For ladies to attend ANC, they needed to suspend some economic activities. If men too were to accompany their wives for ANC, it meant that

more economic activities needed to be suspended and this is able to negatively be more costly.

Generally, research shows that service-related factors are more important than user related factors in affecting male involvement in ANC. The foremost important ones acknowledged include long physical distances from the health Centre, lack of transport network, inconvenient clinic hours, long waiting time at the clinic, poor technical, inter and intra personal skills. Harsh behaviour from service providers is additionally a challenge. Harsh, critical behavior and language from skilled health professionals may be a barrier to male participation and discourages men from returning or participating in maternal health care activities. Byamugisha et al. (2010), reported that harsh, language directed at Ugandan women from skilled health professionals was a social factor that was a barrier to male participation. The rough treatment of men by healthcare providers who discouraged them from returning or participating in antenatal activities. Furthermore, some providers didn't allow men access to clinic settings. Men identified negative attitudes of staff members who lacked common courtesy, due to their “rough handling” of pregnant women and health-care workers not allowing men to enter the antenatal clinic with their partners”. In fact, men experienced healthcare personnel who were always reluctant to encourage male attendance in antenatal care in the least, felt unwelcome and disrespected and thought it had been clear that ANC services were designed without taking into consideration their particular needs. The charging of unofficial user fees was one factor that was cited, the shortage of integration of services was mentioned as discouraging men from getting tested, since they felt they might be “exposed” through special clinics or opening hours (Larsson et al. 2010).

Quality of care at health centers are sometimes pose challenges in male involvement in health-related issues. Health services providers are often

overworked stressed and need to add infrastructure with severely limited resources. In such context, the standard of services is compromised and taking care of male partners is taken into account a further burden (Ntabona, 2002). Clinics are often unable to concurrently accommodate pregnant women with their partners due to lack of space/resources. When there's limited physical space to accommodate male partners they're not comfortable and this will increase the burden and stress of the health providers. While a study undertaken in Turkey showed that doctors weren't supporting men who sought to access in maternal health services, an equivalent study noted that a lot of men came to the clinic with their wives but they stopped at the door (Cigdem et al, 1999).

Research has also indicated that long hours of queuing within the antenatal clinics waiting to be attended to also deter men from involving in their spouse’s antenatal care as men always want to be served fast in order that they will return to their work place (Adelekan et al., 2014a). Recently, literature also indicated that the majority men claimed, they're not involved in antenatal care due to long distances from the health facilities to their houses, lack of enough facilities to accommodate men who participates in ANC services, insufficient staff to attend to them and also as a result of high cost of antenatal services (Nyandieka et al., 2016; Vermeulen et al., 2016). Kwambai et al. (2013) in their qualitative study in western Kenya also suggests that men claimed they're willing to involve themselves in ANC if only they and their wives are going to be given priority first before those women who come without their husbands. This behaviour of men appears to elucidate the very fact that men see themselves to be too busy at work site trying to place food on the table and cannot wish to waste much time at ANC units.

2.6 Establishment of the research gap

Convincing men to attend the antenatal clinic with their partners is one of the gaps which were identified by this study while reviewing the past studies. A literature review is important for any research to be undertaken because it gives the researcher a direction and instances of comparisons. Therefore, it was paramount for the researcher to review all the related literatures of the study under course.

Most of the available information regarding men and ANC relates to HIV testing and the general PMTCT component. More research is needed regarding ways to involve men in the other services offered in the antenatal clinic like the family planning, immunization, etc. There was inadequate research on the role of routine antenatal syphilis screening in engaging men in a woman's pregnancy and the potential influence that STI screening could have in increasing testing coverage of male partners and identifying women at increased risk of HIV acquisition.

Men's use of women as proxies for their own testing suggested limitations in men's understanding of the dynamics of transmission and sero-discordancy. Most of the available information about men and antenatal care came from women and lessons from men who attend a clinic. There was little information about men and couples who did not utilize these services.

3.0 METHODS AND MATERIALS

3.1 Research Design

A Cross-Sectional Survey was employed in this study, since data was collected at one point in time from the sampled men and women in Kafue Ward of Chililabombwe District who represented a larger population

This survey design was suitable for this study because the researcher intended to measure the

factors that affected male involvement in ANC in Chililabombwe. This survey design was suitable for this study because the researcher intended to live the factors that affected male involvement in ANC in Chililabombwe. The rationale for selecting this design was because it offers a quantitative or in other terms a numeric description of the trend's analysis and attitudes and opinions of the population under study.

3.2 Target Population

The target population for this research was defined to include all men and women in Chililabombwe District, while the accessible population was all men and women in Kafue Ward aged 18 years and above as these were within the researchers reach.

3.3 Sample size and sampling procedure

The sample size for this research was 81 men and women. The justification for this sample size, was that it was less costly, manageable, less time consuming and effective. The degree of accuracy will be high and reliable since it is adequately large (above 30 according to the central limit theorem) to be generalized. This provided an opportunity for the data to be analyzed more quickly than it would have been possible with the whole population

The selection of participants during this study was done using stratified sampling. This kind of sampling was used to ensure a reasonably equal representation of the variables for the study. The variables included married men and women and single men and women. This was achieved by writing out the names of the men and women on a piece of paper that was folded and put during a basket. After thorough reshuffling, the researcher selected an element, recorded it, and puts it back within the basket until the specified number is obtained.

3.4 Data collection methods and procedures

3.4.1 Data collection instruments

A questionnaire was chosen as a primary data collection instrument. It was constructed based upon the research objectives of the study.

3.4.2 Data collection procedures

The questionnaire for this study was subjected to a validation process for face and content validity. Face and content validity are defined by McBurney (1994:123) because the face validity which is that the concept a test should appear superficially to see what it's presupposed to test. Content validity is that the notion that a test should sample the range of the behaviour represented by the theoretical concept being tested. Within the validation process of this study, copies of the questionnaire and copies of the questionnaire need to some experts who has adequate knowledge on ANC. These experts went through the questionnaire carefully to work out the appropriateness and adequacy of the instrument.

Having validated the questionnaire, a pilot testing was first administered on the instrument using 20 men and 10 women in Mumba Ward which is not the actual ward in which the study would be carried out. This was done in order to ascertain how the respondents would react to the questionnaire, whether the questions were clear enough and straightforward to understand, whether there was a need to include more questions in certain parts of the questionnaire, and to work out the workability of the proposed method of data analysis for the study.

The mode of administration of the questionnaires was Face to Face (FF). The researcher used this method because face to face generally yields highest cooperation and lowest refusal rates. Furthermore, this method allowed for longer and more complex interviews with high response quality. Finally, the Face-to-Face interview took advantage of the interviewer presence.

3.5 Triangulation

In addition, the study also carried out triangulation which is a process of checking the data collected whether it is correct. Basically, triangulation is a technique that is common in non-quantitative studies. The researcher normally bases their research on a variety of origins of the data (Creswell, 2014). The approach of triangulation is widely accepted in qualitative studies because it strengthens the investigation because of its application of numerous approaches and theories. In this study the researcher applied triangulation by employing a variety sources in data collection. Firstly, the researcher employed questionnaires to collect primary data from the respondents. Secondly, the researcher employed phone call and made some relevant review of literature to ensure that proper triangulation was achieved.

3.6 Data analysis

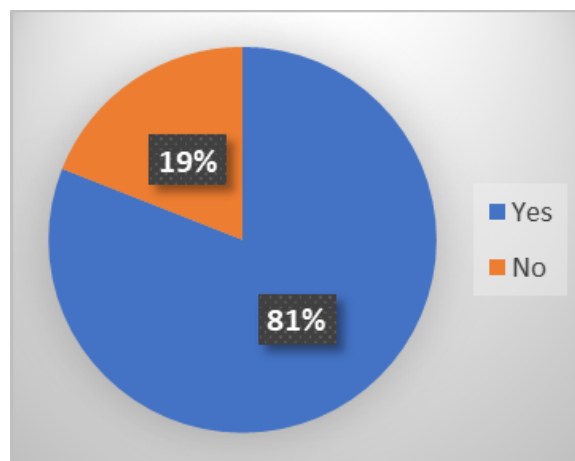
In this study questionnaires were used to collect quantitative data from respondents. The computer software Statistical Packaging for Social Science (SPSS version16.0) was used for processing and analyzing quantitative data. Descriptive statistics were applied to the processed data by showing variable frequency distribution.

3.7 Limitations of the study

The study was limited because the researcher got inaccurate information from the respondents who felt the questionnaires were consuming their time or were not willing to disclose some personal information. More so, the, inadequate financial resources and time constraints impacted on the chances of contacting more respondents.

These limitations were mitigated by making sure that, there was proper sample selection, piloting and careful scrutiny of the perceived parameters of measurement in the data tools, population and sample. Questionnaires, which helped the researcher to attain maximum information from the men and women, were employed with the ultimate

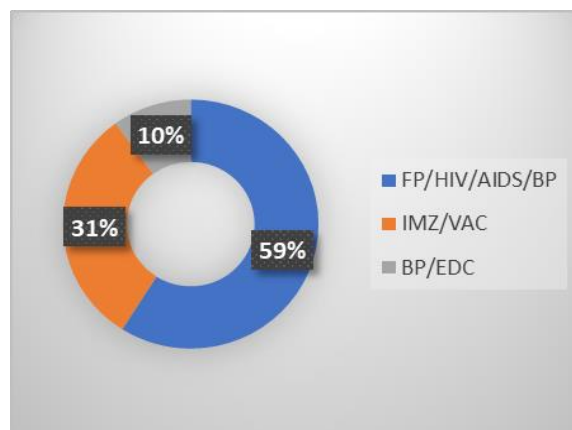
aim of reducing financial and time constraints. The researcher emphasized on the importance of giving accurate information so as to inform practice. The researcher also got maximum cooperation from the relevant authorities and finally working closely with the supervisor at every stage to benefit from all the comments and advice towards the success of these endeavors.



Source: Field data, 2020

The above figure showed that 81% of the respondents had heard about ANC while 19% had never heard about ANC.

Fig 7. Percent (%) distribution of services known in ANC



Source: Field data, 2020

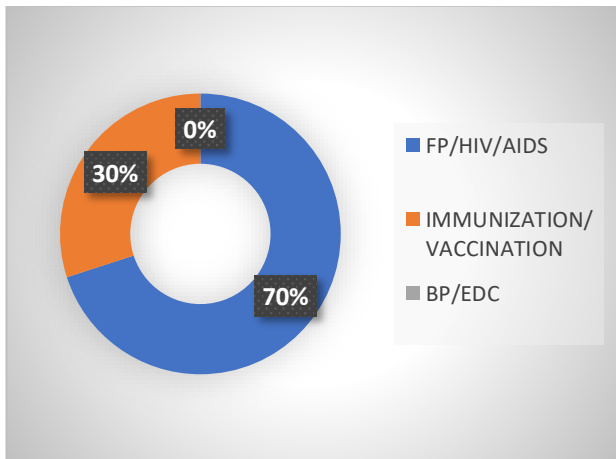
The figure above showed that 59% of the respondents knew of Family Planning (FP), HIV/AIDS and Birth Preparedness (BP), 31% only knew about immunization (Imz) and vaccination (Vac). Only 10% knew about birth preparedness (BP) and early detection of complications (EDC)

Fig 8 Percent (%) distribution of services used by you/your spouse

4 RESULTS AND DISCUSSIONS

4.1 Presentation of Findings

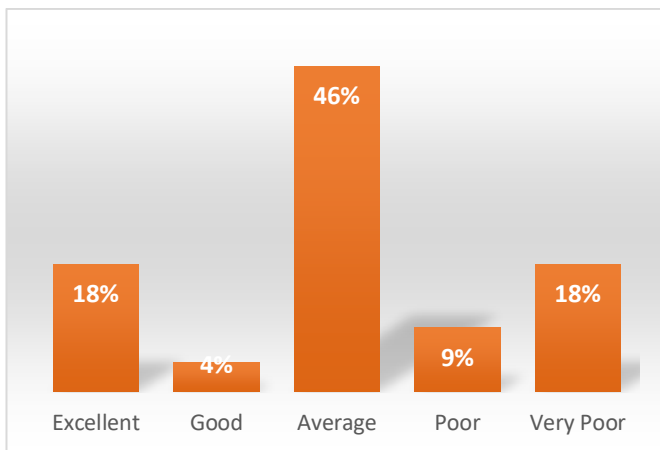
Fig 6. Percent (%) distribution of those that had heard about ANC



Source: Field data, 2020

The above fig shows that 70% of the respondents had used family planning and HIV/AIDS services while 30% of the respondents used the immunization and vaccination services. None of the respondents had used the birth preparedness and early detection of complications.

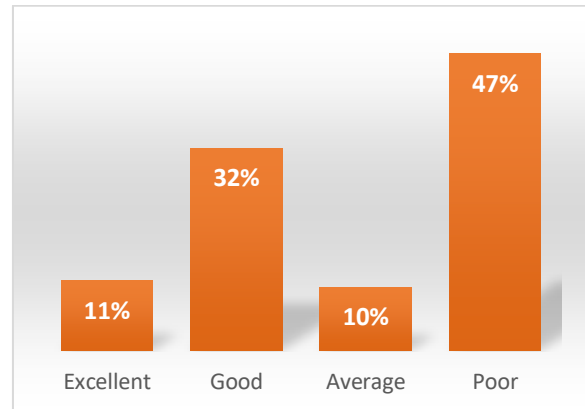
Fig 14 Percent (%) distribution on rating level of knowledge



Source: Field data, 2020

The level of knowledge on the figure above showed that 46% of the respondents had average levels of knowledge on ANC, 18% had excellent knowledge, 9% had poor knowledge. 18% had very poor knowledge about ANC and 4% had good knowledge.

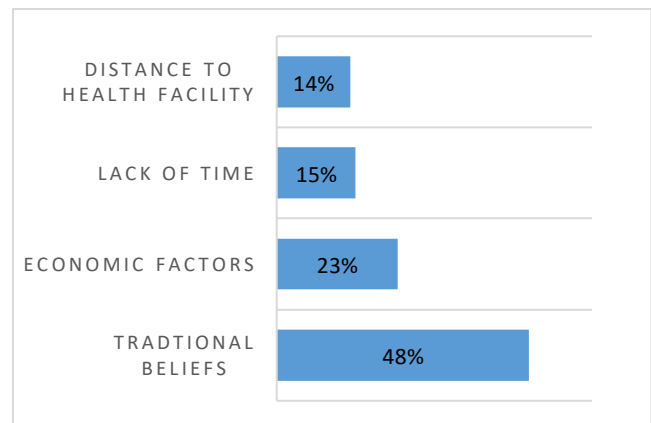
Fig 15. Percent (%) distribution on attitudes of men on ANC services in the community



Source: Field data, 2020

The figure above shows that 47% of the respondents responded by saying that the attitude of men in the community on ANC services was poor, 32% of the respondents' response was that the attitude of men was good, with 11% responded by saying it was excellent. 10% responded that it was average.

Fig 17. Percent (%) distribution on lack of change in men's attitude towards their wives/spouses

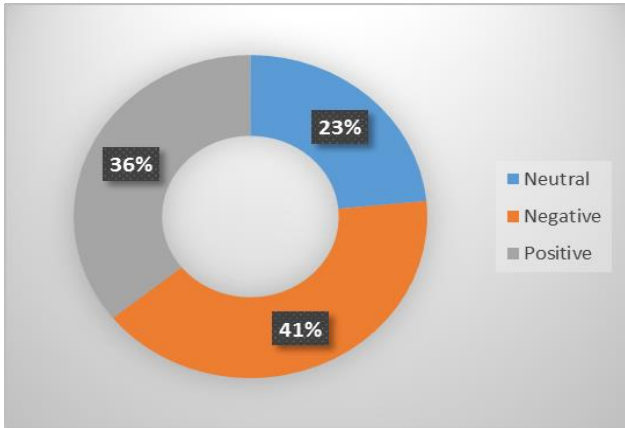


Source: Field data, 2020

The above figure shows that 48% responded that traditional beliefs had contributed to the lack of change in men's attitude towards their wives/spouses. 23% responded that the economic factors had contributed to the lack of change in attitude. 15% responded that it was due to lack of

time. Whilst the rest 14% responded that, it was the distance to the health facility.

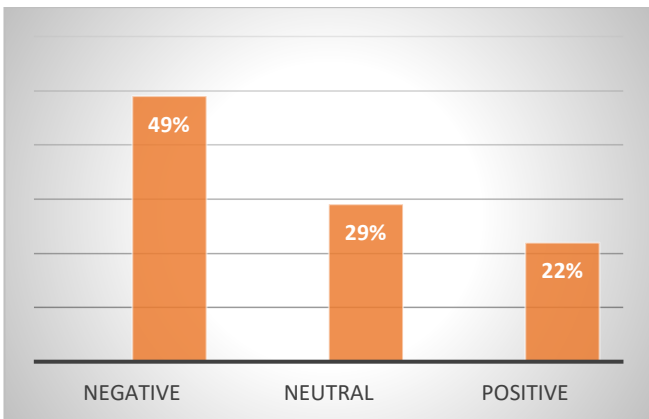
Fig 18. Percent (%) distribution on Attitude of the community towards men’s involvement in ANC



Source: Field data, 2020

The above figure clearly shows that 41% responded that the attitude of the community was poor. 36% of the responded that it was positive whilst 23% responded that it was neutral.

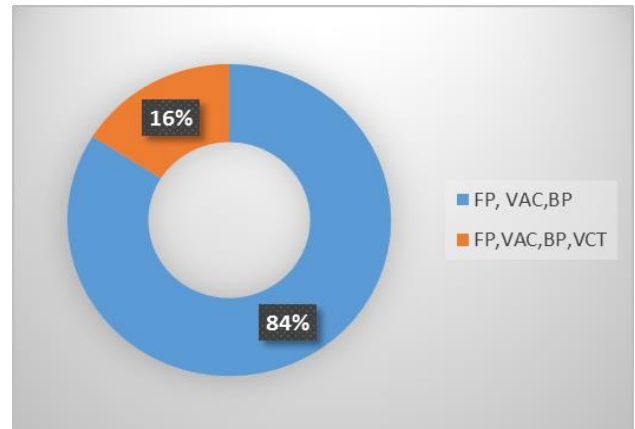
Fig 19. Percent (%) distribution on attitude of health workers towards men’s involvement in ANC at the health facility



Source: Field data, 2020

The above figure shows that 49% responded that the attitude of health workers towards men’s involvement in ANC at the health facility was negative. 29% gave a neutral response. 22% responded that it was positive.

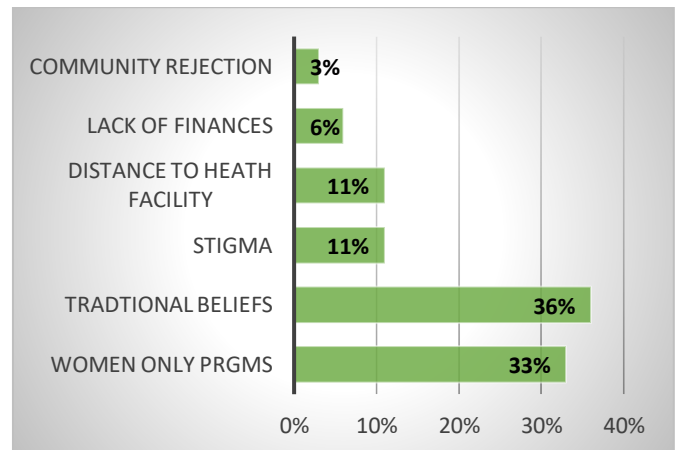
Fig. 23. Percent (%) distribution on services you are comfortable accessing with your wife/spouse



Source: Field data, 2020

The above figure shows that 84% of the respondents were comfortable accessing family planning, vaccination and birth preparedness (FP, VAC, BP) with their spouses. Only 16% of the respondents were comfortable accessing family planning (FP), vaccination (VAC), birth preparedness (BP) and VCT.

Fig. 25. Percent (%) distribution of challenges facing men who accompany their wives/spouses for ANC services.

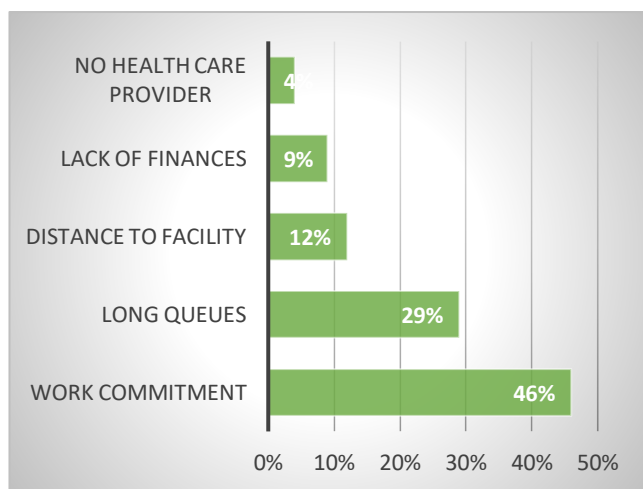


Source: Field data, 2020

The figure above shows that 33% identified women only programmes (WOP) as a challenge for men who accompany their wives/spouses for ANC services, 36% identified traditional beliefs (TB) as

a challenge. 11% identified stigma as a challenge, 6% identified lack of finances as a challenge, and 11% identified distance to the health centre as a challenge whilst only 3% identified community rejection as a challenge

Fig. 26 Percent (%) distribution of factors that can prevent men from attending ANC with their spouses



Source: Field data, 2020

46% of the respondents from the above figure identified work commitment as a major factor to the prevention of men attending ANC with their wives/spouses. 29% identified long queues as a factor that prevents men from attending ANC with their wives/spouses. 12% identified distance to the health facility as a factor that hindered men from attending ANC with their wives/spouses. 9% responded by stating that lack of finances was the factor that hindered men from attending ANC with their wives/spouses. The rest 4% of the respondents identified concerns of there not being a health care provider as a factor that hindered men from attending ANC with their wives/spouses.

DISCUSSION OF FINDINGS

Objective (i) Male Spouse Knowledge on Antenatal Care

This section discussed findings from the research objective number one (i) which dealt with understanding the male spouses' level of knowledge on ANC. This objective is very important because it helps in understanding the levels of knowledge that men have about ANC.

Existence of ANC in the Community

This study revealed that 81% of the respondents had heard about ANC while only 19% had not heard about ANC. The findings of this study show that majority of the respondents had heard about ANC and knew about the existence about ANC in the community. Having heard about ANC showed that the majority of the respondents had some knowledge on ANC and how much male involvement there is in ANC.

On the services offered at the ANC 59% of the respondents knew of family planning, HIV/AIDS and birth preparedness. 30% only about immunization and vaccination. 10% of the respondents knew about birth preparedness and early detection of complications. This showed a variation on their knowledge of what services they knew of when attending ANC with their spouses or alone. From the findings on the knowledge of services offered it can be said that the accessing of ANC was dependent on the services that were known by the respondents and whether the men would be able to accompany their spouses to access this service and get involved in ANC programmes. This could be that the respondents attended different health facilities that were offering only a few ANC services did not have the full birth plan package this in contrast to Gathuto (2014) in discussing the findings of her study highlighted that a birth package included the management of obstetric complications, immunization and the

management of infections, having an idea of the place of delivery and saving money for transport. These findings also showed that some of the respondents also did not possess enough knowledge on the birth preparation plan which included various complications that needed to be detected early this is consistent with the findings of Mersha (2018) who that showed that the scarcity of knowledge about the danger signs during the prenatal period was very high among men. It also showed that the respondents despite living in urban areas their level of knowledge was very low, this is consistent with the findings by the National Statistical Office (2005) that showed that despite living in urban areas the knowledge of pregnancy complications was restricted as compared to those in rural areas.

Service used by you/your spouse

The findings of the study showed that 70% of respondents only using only using the family planning services and HIV/AIDS while 30% of the respondents had used immunization and vaccination services. This showed the low levels of knowledge on the services that are supposed to access by women at the health facility. This according to the researcher is attributed the fact that there is not enough knowledge on the services offered. The variations in services used is dependent upon the services that are known and also attributed to the birth plan that is in place that does not consist of all the services that are supposed to be offered. The reason the higher percentage on the use of family planning and HIV/AIDS was due to the fact that the men wanted to know their HIV/AIDS status and learn more on family planning. The women on the other hand it was compulsory. Katz (2009) showed in the findings of the study done in Nairobi Kenya that men who accompanied their partners to the health facility for ANC did so because they wanted to do an HIV test. The use of family planning can be attributed the education of men on contraceptive use also used

contraceptives themselves. These findings are similar to the findings of Mehta (2002) in a study in Ecuador found that 89% of women wanted their partners to accompany them for their birth control visits with 94% wanted their present during these birth control sessions.

Rating the level of knowledge on ANC

On rating the level of knowledge on ANC on a scale of 1-5, the findings of the study were that 46% of the respondents had average knowledge of ANC, with 23% having excellent knowledge while 18% had very poor knowledge, 9% had poor knowledge and only 4% levels of knowledge were good. The variations in the levels of knowledge can be attributed to the lack of uniform messages and guidelines on the package of care that men should receive whenever they accompanied their partners for ANC services. Furthermore, most men do not attend ANC clinics with their wives or spouses where health information is disseminated and this also contributes to their lack of knowledge on issues that are related to ANC.

Objective (ii) Assess the attitudes of men towards ANC

This section discussed findings from the research objective number two (ii) which dealt with men's attitudes towards ANC. This objective is very important because it helps in understanding the attitudes that men have towards ANC.

Attitudes of male spouses towards ANC

The findings of the study showed that 47% of the respondents still had a poor attitude towards ANC services. 32% had a good attitude while 11% said it was excellent with only 10% saying it was average. The reason from these findings for the poor attitude of men towards ANC with Zambia as an example is because the majority of the health facilities are women which hinders their involvement in ANC services. Furthermore, a visit to the maternity wards there is prohibition of men entering and this results

in the poor attitude if men. The reasons of the poor attitudes of men towards ANC in this study can be attributed to the findings of Britta (2004) who found that roles of men and women on decision making influenced the utilization of ANC services.

Why men's attitudes have not changed towards their wives/spouses when pregnant

The findings of the study showed that the majority of respondents said that traditional beliefs had contributed to why men's attitudes had not changed towards their wives/spouses. 23% responded that economic factors had contributed to the lack of change in attitude. Others considered the lack of time whilst the rest considered the distance to the health facility. The reasons for men's attitudes not changing in this study are similar to the findings of Kalembo et al., (2012) and Clark (2012) who identified social norms which prescribed that it was not the role of men to attend the antenatal clinic and were considered a woman's affair. The findings of this study are also similar to the findings of Ditekemena et al. (2012) and Byamugisha et al. (2010) who identified the negative influence of men's occupations on the men's participation within the antenatal PMTCT program. The findings of this study are also similar to the observation made by Byamugisha et al., (2010), Ditekemena et al., (2012), and Larsson et al., (2010), on the social-economic difficulties and financial constraints being the reason why men were hindered from participating with their wives/spouses in ANC activities.

The attitude of the community towards men's involvement in ANC

The findings of this study showed that the 41% of the respondents who were the majority said that the attitude of the community towards men's involvement in ANC was negative 36% said it was positive while 23% gave a neutral response. The findings on of this study on the response given by the majority of the respondents showed that the

community in Kafue ward still had the notion that ANC services were meant to accessed by the women and girls only while the men should take a back seat due to the various beliefs that they had. The findings of this study are similar to the findings of Nkuoh et al, (2010) who in their study found that the community's attitude towards a man who accompanied his wife/spouse to ANC services was seen as men who were dominated by their wives/spouses. The findings are also similar to the observation made by Chattopadhyay, (2012) and Kwambai et al., (2013) that in many societies that embrace patriarchal social norms, beliefs and culture, male partner does not generally accompany their partners to antenatal or postnatal care services and are never expected to be present during the birth of their children. These norms and values are so much engraved in the minds of the community that they make it difficult for them to break away from them.

The attitude of health workers towards men's involvement in ANC at the health facility

The findings of this study on the attitude of health workers towards men's involvement in ANC at the health facility revealed that 49% of the respondents said that it was negative, 22% said that it was positive while 29% had a neutral response. The response of the majority of the respondents is in agreement with the findings of Mullick (2005) where it was revealed that some health workers are always attached to the thought that maternal health services are for women and as such do not have the initiative to involve husbands to care for their wives/spouses during pregnancy. Further, these findings are similar to the reviewed literature which states that some men were discouraged from attending antenatal health care with their wives or partners due to the tough behaviour of some medical personnel. Men felt unwelcome and disrespected during antenatal health care. In some instances, the doctors mistreated pregnant women and this made men feel uncomfortable and

embarrassed (Auvinen et al., 2013; Byamugisha et al., 2010; Ditekemena et al., 2012; Larsson et al., 2010). Because of this embarrassment many of the men therefore, had no intention of returning for ANC in the unforeseen future.

Objective (iii) Factors affect male involvement in ANC

This section discussed findings from the research objective number three (ii) which dealt with the factors that affect male involvement in ANC. This objective is very important because it helps in understanding the factors that affect men from participating in ANC.

Services that you comfortable accessing together.

The findings of this study on the services that couples are comfortable accessing together the majority of respondents felt very comfortable accessing family planning, vaccination and birth preparedness. With only 16% of the respondents comfortable accessing family planning, vaccination, birth preparedness and VCT. These findings highlighted the fact that the majority of the respondents did not include VCT as one of the services that they feel comfortable accessing together is major factor that affects the involvement of men in ANC. This is despite the fact that the Zambian Government considers VCT has an important component of preventing PMTCT in pregnant women. There is always a fear of receiving an HIV positive result and the confidentiality concerns resulting in some men not be comfortable coming for ANC. Reece et al. (2010) in the findings of their study found that women engaging their partners in PMTCT was a challenge if men were not aware of their status and refused to be tested. Some women also fear being tested together because if they are found positive and their husband/spouse is found to be negative then it means that they will be thought to have been

promiscuous and this may also raise questions as to the paternity of the child.

Challenges facing men who accompany their wives/spouses for ANC services.

The findings of the study on challenges facing men who accompanied their wives/spouses for ANC services showed that the majority of the respondents said that traditional beliefs were a major challenge. 33% of the respondents said that the women only programmes were a major challenge, 11% said that stigma was a challenge whilst 3% said that community rejection was a challenge. Traditional beliefs have been identified as a major challenge because they have focused more on a man just being a provider financially. Furthermore, men do not seek health information and services due to traditional notions of masculinity were seeking help from a health care provider is viewed as a symbol of weakness. It is uncommon in most African societies for men to make decisions on when and how their wives/spouses should seek ANC services. These findings support the findings of Audet et al. (2016) in Mozambique, who reported that the majority of the men who escorted their spouses to antenatal care were also dishonoured in their communities and are made to feel their wives control them. The study further indicated that friends and relatives viewed those men as jealous and weak men. The findings of this study on tradition being a major challenge are also illuminated in the WHO (2007) report were some of the harmful practices included the gagging of women, the varied taboos that prevented women from controlling their own fertility and traditional practices.

Factors that can prevent men from attending ANC with their spouses

The findings of this study on the factors that prevented men from attending ANC with their wives/spouses had the majority of the respondents who stood at 46% saying that work commitment

was a major factor, 29% said that long queues were a major factor, 12% said that distance to the health facility as a major factor while 9% said that lack of finances was a major factor and the rest of the respondents who stood at 4% said that there not being a health care provider was a major factor. The implications of the findings of this study on work commitment as a major factor can be related to the aspect that because men are seen as financial providers of the family, they would be rather working to meet the financial obligations in preparation for the birth of the child with many having the fear of being reported to the relevant authorities if they did not meet that financial obligations. Reece et al (2010) noted that men often spoke about their principal responsibility as providers. Therefore, they considered the time spent at the clinic and away from work or other income generating activities as a barrier to their participation in ANC programmes, the cost of transport and the clinic operating hours were also considered. These findings are also similar to the findings of Ditekemena et al. (2012), observed that, the long distance that men covered so as to attend antenatal health care alongside their wives or partners attracted transport costs or opportunistic costs in terms of loss of your time necessary for them to interact in economic activities to enable them provide for his or her families' welfare. There has also been indication that long hours of queuing according to the findings of Adelekan et al (2014a) indicated that men were deterred from being involved in their spouse ANC as they wanted to be served fast so that they could quickly return to their work place. Frequently women need to await an extended time before receiving ANC services due to burdensome administrative procedures that end in poor patient/client throughout the health facilities. Men, who are within the paid workforce, are often not during a position to spend virtually the whole day participating in ANC services.

CHAPTER 5: CONCLUSION & RECOMMENDATIONS

5.0 Overview

The aim of this study was to investigate the factors that affect male involvement in Kafue Ward of Chililabombwe District. The study adopted a quantitative approach and employed a survey design. The study provided some insight on the level of knowledge of men, the attitudes of men and the factors that affect men's involvement in ANC.

5.1 Conclusion

The study focussed on investigating the factors that affect male involvement in ANC in Kafue Ward of Chililabombwe District. The broad-spectrum of literature reviewed showed that male involvement in ANC might be the beginning for male participation in health issues. However, some men expressed ignorance and did not understand why that they had to be involved. Men attending ANC services with their wives/spouses does not always result in a major increase the knowledge that men had on ANC services offered to the women during ANC visits to the health units on a part of men who attended ANC with their partners compared to those that didn't attend ANC.

Research Question 1: What is the level of men's knowledge on antenatal care services?

The findings of the study showed that although the residents of Kafue ward had a high proportion of male spouses who are aware about these ANC services those that actually accompany their wives/spouses for ANC were very low. The study also found that men who attended ANC had higher knowledge on ANC compared who did not accompany their partners. The study also found that the residents also had different levels of knowledge of what services they knew of when attending ANC with their spouses or alone. The rating of the level of knowledge where varied due to the lack of uniform messages and guidelines on the package of

care that men should receive whenever they accompanied their partners for ANC services. Furthermore, most men do not attend ANC clinics with their wives or spouses where health information is disseminated and this contributes to their lack of knowledge on issues that are related to ANC.

Research Question 2: What attitudes do men have towards antenatal care services?

The respondents from Kafue ward identified that the poor attitude of men towards ANC with Zambia as an example was that the majority of the health facilities had only women programmes that hindered their involvement in ANC services. Furthermore, a visit to the maternity wards there is prohibition of men entering and this results in the poor attitude of men. The residents also said that the community viewed men who accompanied as weak and controlled by their wives/spouses, which contributed to the poor attitude of the men. The health staff also contributed to this poor attitude of men as it was revealed that some health workers always attached importance to maternal health issues for women but did not create initiatives to involve men. Traditional beliefs were found to have contributed to the poor attitude of men who thought was to provide financial support to the woman whilst neglecting the important role that they should play in supporting a woman during pregnancy

Research Question 3: What factors affect male involvement in antenatal care services?

Among the key findings of the factors that affected male involvement in ANC services were traditional beliefs that are a major challenge because the focus on continues to be a man being a provider financially. They do not seek health information on ANC services because it would be regarded as sign of weakness. Work commitment was another important factor that was identified as having affected the involvement of men in ANC. Most men said that they could not accompany their

wives/spouses for ANC because they were usually busy earning support for the family and it was difficult to get permission from work. They could not also afford the luxury of waiting in line at the health facility due to the burdensome administrative procedures that had to be followed before the health personnel attended to them. This usually ended in poor patient/client relationship and a loss of person-hours at work. Men, who are within the paid workforce, are often not during a position to spend virtually the whole day participating in ANC services.

Implications for this research

The main implications of this study whilst appreciating the work done by other researchers this study recognized that the role of men in reproductive decisions based the ANC services is very important however, their role could either promote or hinder women's participation in ANC. The consideration that men are key decision makers in maternal issues, they need to be made to understand the risks and danger signs of pregnancy in order for them to support women during this period. The promotion of men as partners is important if their involvement is to increase. However, the challenge remains that most of ANC programmes in the district are traditionally designed for women only whilst leaving out the men.

The other implication is that since men are at the centre of gender inequalities with the aid of traditions and cultural barriers in patriarchal societies and sexual reproductive health decisions, there is a growing realization that unless men are educated, ANC services will have a limited impact. The unequal gender power relations women especially the vulnerable ones will not be able to negotiate with the men to get involved in the full birth prepared plan, which requires the men to be involved in addressing the dangers of pregnancy in

this plan. This will in turn lead to the high increase in maternal deaths.

5.2 Recommendations for research

The aim of the study was to investigate the factors that affect male involvement in ANC. Moving on forward, with regards of the data generated from the study, if the factors that affect the participation of men in ANC services are not managed well it will lead to an increased number in maternal deaths. It is therefore, important that the following recommendations be implemented to ensure that there is greater improvement in ANC with male involvement.

The Government through the Ministry of Health needs to develop strategies that will help empower men with knowledge about ANC services so that there is an increase the number of men that participate in ANC. It is important that these programmes should focus on the complete birth plan package and not just one component of HIV/AIDS and PMTCT. There is also the need for the promotion of couple-based education on the various birth complications so that the knowledge acquired as a couple can help in managing the pregnancy better

Specific strategies should be put in place that empower men on changing their attitudes towards ANC. These strategies should centre on raising awareness about the importance of male participation at ANC clinics and should involve indabas that bring together various stakeholders that include health personnel, civic leaders, traditional leaders and the other community leaders to discuss the benefits of the participation of men towards changing their attitudes towards ANC and also improving interpersonal skills using information about the community define care. These indabas should also include closed sessions among the male leaders and community leaders when discussing cultural and traditional issues that help shape the attitudes of men.

There should also be the introduction of couple friendly corners specifically for the men to understand fully the role of ANC and build workable relationships with the health care staff so that whenever they visited with their wives/spouses they would feel welcome.

There should be strategies that focus on couples as a unit, with couple-oriented counselling being introduced so that the couples have an equal responsibility in ANC services. It would also be important for health care facilities to consider having flexible working hours for couples to attend the ANC sessions together. This should be done taking into account the men's work schedule, which is one of the major factors that affect the participation of men in ANC services.

There also the need for the training of more health staff and community members and traditional leaders on safe motherhood strategies that centre on male involvement in ANC. This will help in carrying out sensitization programmes to ensure the active participation of not only the men but also the entire community on the best ANC practices.

5.3 Suggestions for Further Research

There is need for more research to look not just at the process and immediate outcomes of men's involvement in ANC, but also to have a longer-term impact on the lives of both men and women. The reality is that despite the considerable rhetoric surrounding men's involvement, men are still not targeted and there are very few evaluations of the interventions in maternal health that fully address issues from a focal point of masculinity, or even an understanding of men's needs.

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