

FACTORS AFFECTING MALE INVOLVEMENT IN ANTENATAL AND
POSTNATAL CARE SERVICES IN ZAMBIA: A CASE OF KABWE
URBAN AND CHAMUKA RURAL AREAS IN CENTRAL PROVINCE.

By

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A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree
Of
MASTER OF ARTS
In
POPULATION STUDIES

UNZA

DECEMBER, 2015.

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DECLARATION

I, MWEEMBA NCHIMUNYA CHRIS do hereby declare that this dissertation presents my own work and that it has not been previously submitted for the award of a degree or any other qualification to the University of Zambia or any other University. All references have been adequately acknowledged.

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APPROVAL

The University of Zambia approves this dissertation of MWEEMBA NCHIMUNYA CHRIS as fulfilling part of the requirements for the award of a Degree of Master of Arts in Population Studies.

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ABSTRACT

Employing both quantitative and qualitative paradigms, the study sought to investigate factors affecting male involvement in antenatal care (ANC) and postnatal care (PNC) services in both rural and urban settings of Zambia. Despite the efforts by the Ministry of Health in ensuring that national health policy guide lines in Zambia are put in place and stipulate male participation in maternal health services, the response is still low. Quantitative data was collected using open-ended and closed-ended questions to 210 respondents which were processed and analyzed using SPSS Version 16.0. Qualitative data was collected using 10 semi structured in-depth interview guide. Other approaches used were, Focused Group Discussion (FGDs), document review and observation. Qualitative data was analyzed by emerging themes.

Among other things, the study 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%). In the study it was also revealed that respondents from urban areas had more knowledge of PNC services (96.2%), slightly higher than their counter parts in the rural areas (89.2%). However, the analysis of the findings show that men from rural areas were more involved in maternal health services (85.7%) as compared to the level 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.

Reflection on the findings seems to suggest that there are many factors affecting male involvement in maternal health services such as socio-economic factors, cultural factors, health factors and residence of the respondents. Factors that affect male involvement in rural areas are different from those factors that are experienced in male involvement in urban areas. In this view the study has highlighted a number of factors that affect male involvement in maternal health services both in rural and urban areas respectively. In the study it was also revealed that men have a perception that reproductive health (RH) issues are exclusively for women.

DEDICATION

This document is dedicated to my beloved wife Mutinta Hamooya Mweemba. Wonderful effort rendered by my Children Twalumba, Chiboola, Chabota, Beenzu, Buumi, Lubono and my niece Milambo.

ACKNOWLEDGEMENTS

No success is ever achieved in isolation. Many hearts and minds contributed to this study. I wish to thank the staff of School of Humanities and Social Sciences, particularly Population Studies Department, for being of great assistance during my period of study. I would like to extend my gratitude to Dr Namunda Mutombo, Dr A. Kapungwe, Dr Musonda Lemba, Dr C. Mapoma for their rewarding lectures and guidance in population studies. I am indebted to Mr. V. Chisumpa, Head of Department Population Studies. May God richly bless them all for their wonderful work and fatherly love. Special thanks should go to my supervisor **Dr. J.R.S. Malungo**, Senior Lecturer at the University of Zambia, who spared time from his busy schedule to guide and advise me relentlessly in my laborious moments of academic distress

I would like to express my heartfelt appreciation to the District health management in Kabwe for availing necessary information to me. I am furthermore, thankful to the **University of Zambia** for providing me with necessary academic training for this study. Special thanks go to the following; my course mates for their cooperation and cordial friendship during the course work, I will sincerely miss the broad smiles we shared, Mr. Chrispine Kamocha from Nkrumah University College for editing my work, i extend my gratitude to my roommate Mr. Alick Sibajane for the friendship and support, I say thank you to all friends, family members, church mates at UNZA SDA Church who have been there for me in all the trying moments. God be with you till we meet again.

Finally, I would like to register my recognition of great appreciation to the participants, Staff in the Ministry of Health. For, they took time to talk courageously and openly about their experiences. It is through their accounts that we can establish and understand the factors contributing to low participation of men in antenatal and postnatal care services. It is to them and to future generations that this study is devoted.

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ABREVIATIONS AND ACRONYMS

AIDS: “Acquired Immune Deficiency Syndrome”

ANC: “*Antenatal care.*”

FANC: “*Focused antenatal care*”

FP: “*Family Planning.*”

GAP: “*Gender and Development.*”

HIV: “*Human Immune Deficiency.*”

ICPD: “*International Conference on Population and Development.*”

IPT : “*Intermittent Presumptive Therapy*”

MCH: “*Maternal and Child Health.*”

MDG: “*Millennium Development Goal.*”

MDHS: “*Malawi Demographic Health Survey.*”

MNCH: “*Maternal Neonatal Child Health*”

PNC: “*Postnatal care.*”

PMTCT: “*Prevention of Mother to Child Transmission.*”

RH: “*Reproductive Health.*”

STDs: “*Sexual Transmitted Diseases.*”

SNDP: “*Sixth National Development Plan.*”

UNFPA: “*United Nation Population Fund.*”

UNICEF: “*United Nations Children’s Fund.*”

WHO: “*World Health Organization.*”

CHAPTER ONE

1.0 BACKGROUND AND INTRODUCTION

1.1 Introduction

This chapter presents the background, statement of the problem, purpose of the study, objectives of the study, research questions, and significance of the study. It also presents the delimitations, limitations, and study variables, definition of terms. It further explains the conceptual framework, and organization of the study. Finally, the summary of the chapter has been presented.

1.2 Background

1.2.1 Global perspective

Too often in the past, men were presented as an obstacle and not as part of the solution in antenatal and postnatal services (Ntabona, 2002). The majority of interventions and services to promote sexual and reproductive health, including care during pregnancy and child birth, have been exclusively focused on women. Yet, men and women living in the same society are influenced by the same beliefs about the roles and responsibilities that are appropriate for each gender (Ntabona, 2002).

The behavior of men, especially their beliefs and attitudes towards participation in maternal health care affect the maternal health outcomes of women and their babies. The exclusion of men from maternal health care services could lead to few women seeking maternal health services and as a result, worsening the negative maternal health outcomes for women and children. Increasingly, recognition is growing on a global scale that involvement of men in reproductive health policy and service delivery offers both men and women important benefits (Naomi, 2005).

Towards the end of the 1980s, the women's empowerment approach became an important driving force within health promotion and, more particularly, within sexual health promotion (Stein, 1997). However, as a strategy the empowerment of women without the involvement of men is at best a partial solution and at worst could create more problems or conflict and result in more problems by increasing men's feelings of alienation towards these programs which were not categorical to exclude men in essence but were just never appealing to them (Stein, 1997).

Greater male involvement in maternal health programmes may help to reduce unwanted pregnancies and transmissions of sexually transmitted infections as well as improve child survivals (WHO, 2004.).

The introduction of the Safe Motherhood Initiative which was initiated in 1987 had little effect on maternal and child mortality which remained the human development indicator showing the widest disparity between rich and poor nations, with the life time risk of a woman dying from causes related to pregnancy and child birth nearly 40 times higher in developing than in developed countries (World Health Organization and UNICEF 1996).

Globally, low male involvement in maternal health care services even now remains as a problem to health care providers and policy makers for a long period of time. During the 1980s, UNICEF (2009) reports that globally, more than 500,000 mothers die each year from pregnancy related conditions, and neonatal mortality accounts for 40% of the estimated 9.7 million children under-five deaths. Because of these alarming mortality figures, many global meetings were held to address the issue of maternal and infant mortality such as the Cairo International Conference on Population and Development (ICPD) in 1994, and the Beijing World Conference for women in 1995 where a lot of emphasis has been to encourage male involvement in reproductive health, including maternal health. The Beijing Conference emphasized on men's proactive attitudes and knowledge base to reproductive health (WHO, 2007).

The 1994 ICPD in Cairo the participating nations (179) agreed on the plan of action, which stated that "changes in both men's and women's knowledge, attitudes, and behavior are necessary conditions for achieving a harmonious partnership between men and women (UNFPA, 2004). This would open doors to gender equality in all spheres of life, including improving communication between men and women on issues of sexuality and reproductive health, and improving understanding of their joint responsibilities (UNFPA, 2004: 29).

The 1994 International Conference on Population and Development (ICPD) further stated that there has been increased attention around the world on constructive male involvement in reproductive health. According to the ICPD ten year progress reports, a major challenge was the promotion of greater male responsibility in family and reproductive decision-making (UNFPA,

2004). Reproductive health practitioners have recognized the significance of targeting men in programs, since men can significantly influence their partners' reproductive health decision making and the use of health resources effectively (Metha, 2002). It is important to understand men's behavior and their point of view because men have a strong influence on women's health and their access to care (Young and Kols, 2002). Male involvement is a key to reproductive and health community. The word Reproductive health implies both men and women are partners in reproductive and sexuality. Men's reproductive health and their behaviors impact on women's reproductive health and children's well-being and society as well. Following that action plan there is a positive trend globally of increasing male involvement in reproductive health including maternal health services though without challenges. Studies done in several countries have reported cultural, social economic, program factors, policy issues and communication issues as the factors influencing male involvement in maternal health services (WHO, 2004).

In 2001, the World Health Organization (WHO) issued guidance on a new model of Antenatal Care (ANC) called goal-oriented or Focused Antenatal Care (FANC), for implementation in developing countries (Villar et al, 2001). In this new strategy of focused antenatal care, WHO recommends four (4) antenatal care visits in low risk pregnancies and prescribes the evidence-based content for each visit. Antenatal care constitutes screening for health and socio economic conditions likely to increase the possibility of specific adverse pregnancy outcomes, providing therapeutic interventions known to be effective; and educating pregnant women about planning for safe birth, emergencies during pregnancy and how to deal with them (WHO, 2009). In addition, the interventions that have proved to be of great benefit to the mother and the child could only be achieved with full participation of men in maternal health care such as obtaining iron and folate supplementation in areas with high prevalence of anemia, serological screening for and treatment of syphilis, routine obstetric examination, intermittent presumptive therapy (IPT) for malaria, and tetanus, immunization (Van Eijk, 2006).

1.2.2 Sub-Saharan Situation

Maternal and neonatal morbidity and mortality have continued to be a major problem in developing countries despite efforts to reverse the trend, ninety nine percent (99%) of maternal and new born mortality occur in Sub-Saharan countries (UNICEF, 1999). Despite international

and government efforts to increase the provision of a basic package of essential maternal health services, the majority of women in developing countries are still not able to access these potentially life-saving services partially due to low male involvement in maternal health services. Involvement of men in health services may be an actual component in increasing access to these life serving services.

In sub-Saharan countries, shortages of skilled health workers and equipped facilities, and the often unequal distribution of existing health resources, create barriers to care for large segments of the population. There is a growing continental commitment to reduce the unacceptably high maternal death rates in developing countries. However, progress towards this goal in sub-Saharan Africa demands international cooperation to assess the causes of maternal death and provide guidelines regarding maternal care to ensure that quality health services are rendered effectively (UNICEF, 1999).

In the recent years the policy focus has increased for Maternal, Newborn and Child Health (MNCH) in Africa. The African Union now has three regional strategies in various stages of development; Road Map for reduction of maternal and newborn mortality (USAID, 2004); Child survival Framework (USAID, 2005); Maputo Sexual and Reproductive Health and Rights Plan of Action. Each of these policy frameworks allow for national government adaptation and implementation in countries with support from partners under the principles of the Paris declaration on Aid effectiveness. Already, 35 countries in Africa have started the process of a national Road Map which was initiated through the MNCH Task Force in 2004. These policy frameworks represent a great advancement, but they are only the first step on the road to lives saved through increased coverage of essential interventions. The time is short for sub-Saharan countries to achieve these policies there are only few (2 years) years left before the 2015 target for the Millennium Development Goals (MDGs) which is a set of targets agreed by 192 countries in 2000 which aimed to halve world poverty by 2015, (USAID, 2006).

In order for African countries to achieve the Millennium Development Goal of reducing maternal mortality by three quarters (MDG 5) by 2015, it requires a 5.5 annual average reduction of maternal mortality. However, the actual reduction in Sub Saharan Africa between 1990 and

2005 was only 0.1 percent (WHO, 2008). The slow progress in reducing maternal mortality is partly a result of low male involvement in maternal health services and in some cases where services exist, some husbands have reportedly denied their wives to seek maternal health services. Research showed that men not only acted as gate keepers who restricted women and children's access to health services, but also through abuse or neglect, man's actions had direct bearing on the health of their partners and their children (Gallen et al. , 1986). The failure to incorporate men in maternal health promotion, prevention and care programmes by policy makers, programme planners and implementers of maternal health services in Sub-Saharan countries has had a serious impact on the health of women, and success of the programmes (Greene et al. , 2004). Yet the huge majority of African women are still unaware of their fundamental rights to health and they continue to suffer from social- economic discrimination and unwanted pregnancies which may be potentially harmful to their health (WHO, 2008). Despite the availability of a few contraceptive methods for men, maternal and child health (MCH) programs provide most Reproductive Health (RH) care, strategic plans and services lack indicators for men and most service providers are not equipped or trained to accommodate male clients. Reproductive health facilities tend to be female-oriented; as a result, men are often reluctant to avail themselves of services. Men's reluctances to attend antenatal and postnatal care services jeopardize the well-being of both mothers and children.

1.2.3 The *Zambian Situation*

Zambia faces significant challenges to maternal, infant and young child survival rates. The past five years has recorded a decline in young mortality. However, the rates still remain in unacceptably high at 591 maternal deaths occurring per 100,000 live births while the infant, neonatal and under five mortality rates are at 70, 34 and 119 per 100,000 live births, respectively (CSO et al, 2007). These mortality rates are unacceptably high. The major causes of child mortality are malaria, diarrhea, and anemia. Malnutrition has been on the increase, attributed to the worsening poverty levels and increase in food insecurity, as well as sub optimal infant and young child feeding practices. According to available statistics from Zambia Demographic and Health Survey, 70 percent of the population is food insecure and 45 percent of children are stunted while fifteen percent of children are under weight (CSO, et al., 2007). These rates are among the highest in the region. There is also a general critical deficiency of micro- nutrients

(iodine, iron and vitamins), among children and expecting mothers amongst the Zambian communities.

The Maternal Mortality Rates (MMR) in Zambia has decreased from 729/100,000 to 449/100,000 live births during the period 2001-2007 (CSO et al, 2007). This is a great achievement. However, more hard and collaborative work is needed to reduce it further. In Zambia antenatal care services are provided free of charge in most government health institutions and a minimal cost in private clinics. As a result, the Zambia Demographic and Health Survey indicate that the vast majority (94%) of pregnant women receive some antenatal care (ANC) from a skilled health provider, most commonly from nurses/midwife (87%). However, 19% of women attended antenatal care by their fourth month of pregnancy as recommended by World Health Organization (CSO et al., 2007). Furthermore, in terms of urban and rural variation, 21% of pregnant women in urban and 18% in rural districts had their first antenatal visit by fourth month of pregnancy.

A study done in Mpongwe, one of the rural districts in Zambia, showed the same trend. Out of 6,448 first antenatal attendance in 2008, only 2,296 pregnant women attended antenatal by the 20th week of their pregnancy, representing 74% of late antenatal attendance. The average number of antenatal care visits per pregnancy was 2.6. Similarly, the Ndola 2008 HMIS report indicated that only 30% of pregnant women attended antenatal by 20th week of pregnancy. Out of 19,964 first antenatal attendances, only 5,992 attended by 20th week of pregnancy making the proportion of late ANC attendance stand at 70% (HMIS, 2008).

Although the health policy in Zambia provides for the inclusion of men in antenatal and postnatal care (ANC/PNC), its implementation poses daunting challenges. Targeting the general male population is not yet a priority for most health services in Zambia. While most services operate an open-door policy for men, the number of more specific initiatives directed at men is limited. Moreover, in the private health sector, many practitioners are men, who, if properly trained and equipped, could be an important resource in encouraging men to use RH care.

So far, there is little evidence indicating a comparative research having been done on factors affecting male involvement in maternal health care in both rural and urban areas. However, the

limited research that has been carried out has mainly focused on levels of male involvement in reproductive health (Benkele, R. G, 2008).

1.3 Statement of the Problem

Since the Cairo international conference on population and development (1994) and the Beijing World Conference for Women (1995) Zambia, as a signatory to the World Health Organization, pledged to have reduced the maternal and child mortality levels by 2015 in order to achieve Millennium Development Goal number 5. Despite the efforts by the Ministry of Health in ensuring that national health policy guidelines in Zambia is put in place and stipulate male involvement in maternal health services, very few men are training as health practitioners and get involved in maternal health care (Ntabona, 2002). As a result the researcher wondered what factors affect male involvement in antenatal and postnatal care services in Zambia. This knowledge gap prompted the researcher to conduct a study to determine what factors affect male involvement in antenatal and postnatal care services in Kabwe urban and Chamuka rural areas in Central Province. This gap needs to be urgently addressed in order to come up with effective interventions and policies in accelerating male involvement in maternal health care. Therefore, this constitutes a problem thus, the need for this study.

1.4 OBJECTIVES

1.4.1 General Objective

The general objective of the study was to investigate factors associated with male involvement in antenatal and postnatal services in urban and rural settings of Central Province.

1.4.2 Specific Objectives

The specific objectives of the study were to:

- i. Determine male spouses' knowledge of antenatal and postnatal care services,
- ii. Assess the attitudes of the male spouses towards antenatal and postnatal services
- iii. Determine the factors affecting male involvement in antenatal and postnatal care services in the urban and rural settings and
- iv. Establish the differentials of male involvement in antenatal and postnatal care services between rural and urban areas.

1.5 Main Research Question

The main research question was to investigate factors associated with male involvement in antenatal and postnatal care services in Kabwe urban and Chamuka rural areas?

1.5.1 Specific Questions

The specific research questions were:

- i. What determined male spouses' knowledge in ANC and PNC services in rural and urban areas?
- ii. What attitudes did male spouses have towards ANC and PNC services uptake?
- iii. What factors affecting male involvement in ANC and PNC services in urban and rural areas of Central province?
- iv. What were the differentials of male spouse involvement in antenatal and postnatal services between rural and urban areas?

1.6 Significance of the Study

It is hoped that information obtained from this study may add to the existing body of knowledge in the area of maternal and child health. The results of this study might also be of use to health policy makers and other stake holders for developing healthy public policies as regards reproductive health. Consequently, the findings might help to enhance family and social support system for pregnant and breastfeeding mothers in communities.

The study will also contribute to the existing body of knowledge with regard to; what is known about male involvement in maternal health services, the levels of male involvement in maternal health, attitudes and practices of spouses towards male involvement and the differentials of male involvement between rural and urban settings. Information generated from the findings may be further used to provide decision-making and actions that would lead to increased male involvement in maternal health services. This might further enable policy makers to formulate a new health policy or to revise the existing one which is merely on paper and not pragmatic. Furthermore, the findings of the study may enable the policy makers and health providers to design appropriate programmes or interventions to curb the men's ambivalent attitudes towards ANC and PNC services. Consequently, the findings of this study may also ignite further research

and may ultimately enhance reduction in maternal and infant morbidity and mortality at provincial and national levels.

The study was therefore, important in that it sought to investigate factors affecting male involvement in antenatal and postnatal care services.

1.7 Conceptual Framework on male involvement in maternal health services

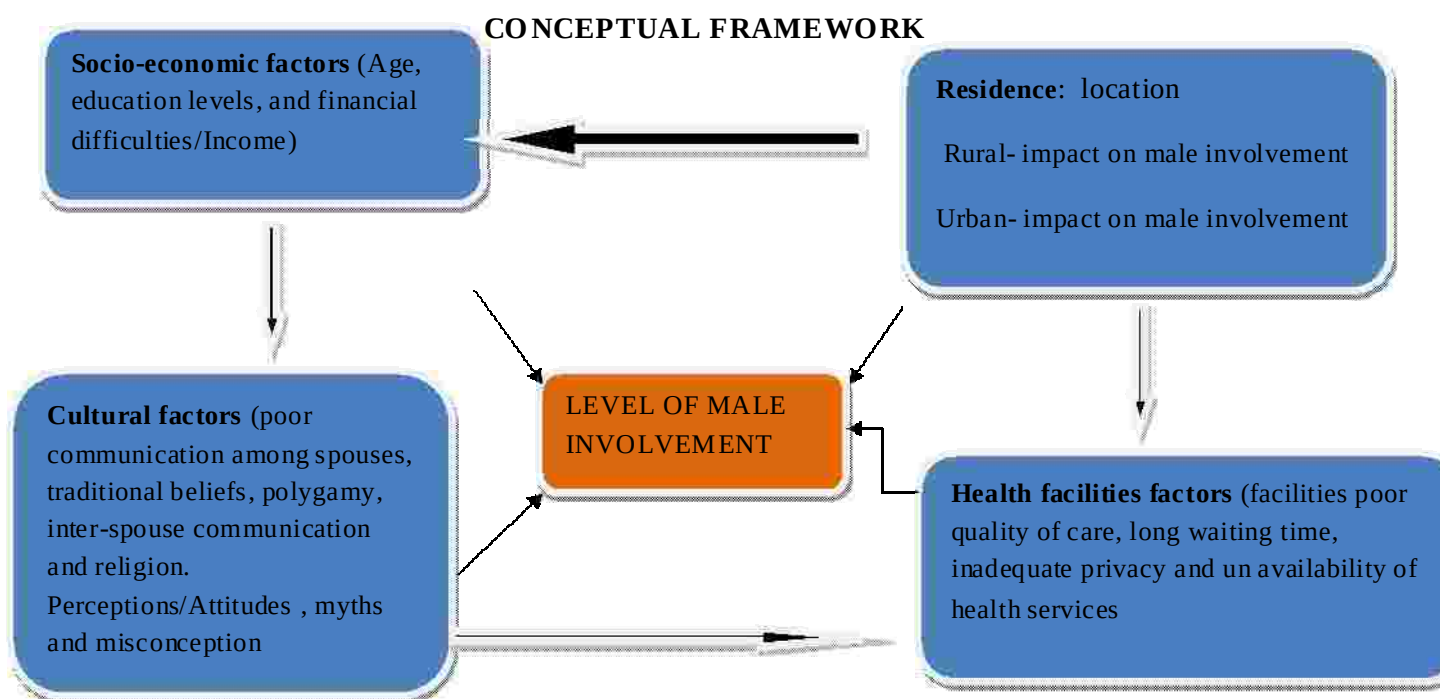
The study adopted a conceptual framework that link male involvement to the various factors that determine levels of male involvement in antenatal and postnatal care services. There are intricacies which manifest in the male involvement in maternal health care services that are as a result of residential factor (rural/urban), socio-economic status, cultural and health care factors.

The framework showed that there were various factors that influenced ideal performance of male spouses in both rural and urban areas. The background variables in the conceptual framework included factors such as the residence, institutions such as schools, churches and hospitals or clinics; occupation affect male participation in maternal health services both in rural and urban areas. People in rural areas are busy in finding ways of surviving where as in urban area people have busy schedule with their daily activities as a survival strategy and have little or no time on maternal health services. The proximity or location of the health centers disadvantages the health users due to distance, for example most of the health centers in the rural areas are located in distant places. On the other hand location of the household to some extent could have a bearing on the uptake and the knowledge of the health services to the male partners. In addition, there is inadequate sensitization due to limited media as compared to those in urban areas. Despite having health centers near to their homes in the urban areas the response in male involvement in maternal health services is still poor. Residence as a background variable has direct impact to both the independent variable (social-economic and health facilities) as well as the dependent variable which is male involvement in maternal health services.

This conceptual frame work which was presented by Thaddeus and Maine (1994) was referred to social economic. In both rural and urban areas accessibility to social economic facilities affect male participation in maternal health services due to social demands which include: food, finances, shelter, water, education and transport. These are crucial factors which influence maternal morbidity and mortality. For instance, education attainment has a direct impact on male involvement as regards to levels of knowledge of awareness in health pertaining services.

Male involvement in maternal health services is also negatively affected by cultural factors which include; Polygamy, this has been associated with family wrangles that may hinder the man from treating his wives equally. Absence of inter-spousal communication and discussion can affect male involvement in ANC and PNC services. This can prevent men from taking appropriate measures in maternal health decisions. In addition, in most societies male involvement in maternal health services is regarded as a taboo as a result, male participation is limited. Furthermore, in some African societies it is an abomination for a man to see the nakedness of a woman; it is against the norms and morals of societies. However, if not revisited the cultural factors may hinder male participation in the maternal health services.

Health care factor as an independent variable has an effect on male participation on maternal health services. Therefore, health factors in this study include: Lack of privacy in the health centers, lack of comfort, compromised confidentiality and poor attitude of health workers. Adversely affecting men's involvement in maternal health care services and waiting time at the health centers. Perceptions and attitudes of health providers towards male involvement in maternal health services, undeniably, have negative impact on the participation of men in health related issues.



Adopted from Thaddeus and Maine (1994)

1.8 Operational Definition of Key Terms

ANC: Ante-natal Care Services is health care given to a mother and partner during pregnancy

Delivery Care Services: Is health care given to the pregnant mother after onset of labour until complete expulsion of the baby, placenta and membranes

Involvement: Involvement is to make a matter of concern or affect somebody or to make somebody to Participate

Male: Male refers to a man of the age eighteen years and above, having a right to marry and to start a Family (Constitution of the Republic of Zambia 1964)

Maternal health services: Maternal health services for purpose of this study refer to antenatal and post natal care

Male Involvement in maternal health services: Male involvement in maternal health services is when a man discusses maternal health issues with the spouse and they make a joint decision as a couple, accompany the partner to seek maternal health services

Postnatal care: Postnatal care is health care service given to the mother and the baby after child birth up to the period of six weeks.

1.9 Organization of the Dissertation

Chapter One presents the background of the study on the salient factors affecting male involvement in antenatal and postnatal care services. It gives a statement of the problem, description of the study variables and further explains the significance of the study.

Chapter Two reviews literature related to the study. This includes definitions of concepts related to maternal health services; it looks at accessibility and utilization of health services by spouses, knowledge on male involvement in health services, levels of male involvement between antenatal and postnatal care services salient factors affecting male involvement in health services, differentials of male involvement in health services and lastly the attitudes of people towards male involvement in health services.

In Chapter Three, the study further elaborates on the methodology that was used. This involved explaining the method employed in data collection and analysis. This includes the research

design, target population, sample and sampling procedure, and research instruments used in the study.

Chapter Four presents the findings, whereas Chapter Five discusses the findings. Chapter Six presents the conclusions and recommendations.

1.10 Summary

This chapter delved into the background of male involvement in antenatal and postnatal care services by providing a panoramic view of the Global male involvement in health services and historical perspective on male involvement in maternal health (ANC and PNC) services in Central province. It also explored the problem focusing on the uptake and adherence of maternal health services. In the same vein, the purpose of the study was to investigate the factors affecting male involvement in antenatal and postnatal care services.

Based on the four objectives of the study, the research questions attempted to focus on the factors affecting male involvement in antenatal and postnatal care services. As no research goes without delimitations and limitations, this chapter discussed the restrictions which hampered the research. In this chapter, study variables both dependent and independent variables have been discussed, operational terms and acronyms have been defined. For better understanding of the study, this chapter also explored a conceptual framework.

The next chapter reviews the literature relevant to this study.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction.

This chapter presents literature documented on the factors associated with the male involvement in maternal health services of the health users. A variety of factors affecting maternal health services have been discussed. Starting with the accessibility and utilization of health services; Knowledge on male involvement in maternal health, levels of male involvement between antenatal and postnatal care services. Discussed further were the salient factors affecting male involvement in antenatal and postnatal care services, differentials of male involvement in maternal health services in rural and urban areas and lastly, the attitudes of spouses towards maternal health services and the punitive behavior of health providers towards spouses.

2.1. Definitions of the concept of maternal health services

The safe motherhood initiative, which was launched in 1987 by WHO, UNICEF and UNFPA, the World Bank and other organizations placed maternal health at the fore front of International Public Health (Family Care International, 1997). Maternal health is a state of complete physical, mental and social well- being of the mother; it is a resource for everyday life of the mother. Maternal health care services comprise of a wide range of health services given to the mother before pregnancy, during pregnancy, labour and after delivery. Maternal health services include the following, preconception care, antenatal care (ANC), Prevention of Mother to Child Transmission of HIV (PMTCT), safe delivery (intra-partum care), postnatal care (PNC), and emergency obstetric care. However for the purpose of this study maternal health services refers to antenatal and postnatal care services.

2.1.1 Antenatal care

According to World Health Organization (WHO, 2001) the content of antenatal care visits include; blood pressure measurement, urine testing for bacteria, blood testing for syphilis, immunization for tetanus , providing iron tablets and teaching women about danger signs of pregnancy complications. The World Health Organization (WHO) recommends a minimum of four antenatal care visits, based on reviewing the effectiveness of different models of delivery service.

Antenatal care (ANC) is an important determinant of safe delivery. Although certain obstetric emergencies cannot be predicted through antenatal screening, women can be educated to recognize and act on symptoms leading to potentially serious conditions (Bhattia and Cleland, 1985). This is one strategy for reducing infant and maternal mortality. One of the most important functions of antenatal care is to offer health information and services that can significantly improve the health of women and their infants by involving men. Antenatal care during pregnancy appears to have a positive impact on the utilization of postnatal health care services therefore, it is imperative that men are equally involved in the uptake of this health service.

A study done in Mbale region, Uganda, for male involvement in ANC services, used male involvement index to measure the level of involvement of spouses. The study was a cross-sectional survey of 388 men aged 18 years and above, whose spouses were attending antenatal care at Mbale Regional Referral Hospital. The respondents had a median age of 32 years. The majority (74%) had a low male involvement index and only 5% of men accompanied their spouses to the ANC (Byamungisha, et al, 2010). The findings show that men who had 8 or more years of education were 2 times more likely to get involved in the ANC than those with less education. Those who knew their HIV sero-status were four times more likely to get involved in ANC programme (Byamungisha, et al, 2010). Only 18 (4.7%) of the 387 men had attended ANC with their spouses, but most of them (377 (97%) out of 387) provided financial support to their spouses to attend ANC. The majority of respondents (236 (61%) out of 387) had not asked their partners whether they (the men) could use condoms during sexual intercourse with them (the women). Only 99 (26%) of the 387 respondents had a high male involvement index in antenatal services uptake adherence

Societal allocation of roles to the men and women especially decision making influences utilization of ANC. It is therefore important for men to understand and appreciate the importance of attendance of ANC services at a health facility. A study done by Britta et al., (2004) in Nepal revealed that only 40% of the husbands accompanied their women attending ANC for the first time and that greater decision-making power for women was associated with lower husband accompaniment to ANC and lower overall male involvement. In effect men's involvement in the maternal health care system often stops at the doors to the clinic, yet to exclude men from information on the benefits of ANC, counseling and health services is to ignore the important

role men's behaviors and attitudes may play in a woman's maternal health choices (Platin, 2007, Lester and Moorsesom, 1997, quoted by Britta, 2004).

A study done in Luapula Province in Zambia on male involvement in PMTCT reveals that an increasing number of men are proving that they can be true partners in the antenatal services and fight against HIV/AIDS in Zambia, where the HIV epidemic continues to disproportionately devastate women and girls. In Luapula Province, husbands and boyfriends have started to travel with their pregnant partners to antenatal clinic visits, encouraging their wives to get health checkups before giving birth (Tshibumbu D., 2006). Through PMTCT programs, nearly 70 women are tested and counseled at the antenatal care clinic each month, and 75% of the clients who attend the clinic at the health centre come with their husbands (Tshibumbu D. 2006).

Another study done in Chipata, Zambia also reveals that males were not fully participating in PMTCT and reasons given were lack of information and lack of direct link between PMTCT staffs and males (Benkele R.G. 2007).

2.1.2 Postnatal care services

The Postnatal care is the period just after delivery and through the first six weeks of life (WHO, 2005). This period is recognized as a critical time for both mothers and newborns. The importance of postnatal service has been reported in various studies Worldwide (Titaley C, 2008). Postnatal services enable health professionals to identify post-delivery problems including potential complications and to provide treatments promptly. Research findings have shown that a large proportion of maternal and neonatal deaths in Zambia occur during the first 24 hours after delivery. Prompt postnatal care is important for both mother and the child to treat complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child (CSO et al., 2007). In Zambia it is recommended that all women receive a check on their health within six (6) days of delivery (CSO et al., 2007). According to the Ministry of Health Report (2008) high numbers of mothers (86%) attend the first antenatal booking mainly and about (52%) of mothers attend postnatal care services. The decline in ANC and PNC visit attendance by women could be as a result of low male involvement in these services. Active male involvement and participation in maternal health services is necessary to increase utilization of maternal health services by the pregnant women and mothers.

If men are well sensitized about postnatal care services and their concerns addressed, the number of mothers seeking postnatal care services is likely to increase (Ntabona, 2002). It is important therefore for all stake holders to realize that postnatal care services is not just a woman's issue we have now seen that a mother's health has a direct bearing on the health of her new born. Men if properly sensitized could serve as agents to bring more women to accept and utilize postnatal care services; Increased male involvement and participation in postnatal care services can be achieved in the way men accept and support their partner's needs, choices and rights (Ntabona, 2002). A number of studies have shown that the presence of husbands in the labor wards shortens the labor, reduces pain, panic and exhaustion of the woman (Kennel et al, 1991, WHO, 2010). .

According to Kaona F.A.D (1990), the early identification of postnatal complications for both mother and baby can reduce maternal and newborn morbidity and mortality. Despite a beneficial impact, postnatal care services are underutilized particularly among those who are in the greatest need (Kaona F.A.D. et al. 1990). The study further reveals that about 80% of antenatal clinics in Kenya offer PMTCT services but the uptake of counseling and testing is below 50% (UNAIDS, 2010).

2.2 Accessibility and utilization of ANC and PNC services by couples.

The goal of maternal health care services is to ensure that no woman or new born dies or incurs injuries due to pregnancy or child birth. However to achieve this goal, maternal health service providers and planners need to view this service in the context that women's potential to control and improve their wealth as well as their health is more limited than men's in most parts of the world (Engender Health, 2008). This prevents women from accessing critical health information and services and can lead to poor reproductive, maternal and child health outcomes, including unwanted infections and unwanted pregnancies. Because men have a strong influence on women's health and their access to care, the need for male involvement in antenatal and postnatal care services is clear and male involvement is becoming even more critical in the delivery and uptake of maternal health care services. In order to encourage improved reproductive health, emphasis needs to be focused on the understanding of men's reproductive behavior and the influence to their wives (Adamehak and Adebyao, 1997).

Physical accessibility of health services has been an important determinant of utilization of health services in developing countries. World Health Organization reported that distance from MCH services, and the time and the cost involved in travelling to services are significantly associated not only with antenatal use but also with the use of institutional delivery, postnatal and infant care services (WHO, 2006). According to WHO, a reasonable distance to the health facility should be about five to ten kilometers (Dennill et al., 1999). Smart (1996) states that the environment in which services are provided for young people should be appealing to them, probably by avoiding the clinical atmosphere often associated with hospitals or hospital-based care.

2.3 Knowledge on male involvement in ANC and PNC Services

Inadequate knowledge about antenatal and postnatal care and the benefits derived from it for the mothers and newborns has negatively influence utilization of maternal health services. Sometimes pregnant women especially adolescents, may not be aware of the problems that result from not attending maternal health services (Mutale et al., 1991). Lack of knowledge about dangers of not seeking health care in pregnancy and delivery, including inability to make independent decisions were major barriers to seeking health care among pregnant women in Uganda (Mutua, 2004).

Around the World, men play critical roles in women's ability to seek health care, yet more often than not, they are uninformed about women's reproductive health needs or their own. It is believed that when male and female are aware of each other's health needs, they are more likely to receive services. It is imperative to note that to increase male involvement in maternal health services requires the providers to gain in-depth knowledge and understanding of the men's health perspectives, behavior and practices. Although pregnancy is treated not as an illness, it creates a lot of physical and emotional demands on the mother. The awareness about the demands of pregnancy on the part of the husband and other family members could result into the necessary support the pregnant woman needs from the family members including the husband. The husband is often the primary decision maker, and wife's economic dependence on her husband gives him greater influence on major household decisions as was reported in Nepal by Britta and others (2004) where 50% of the women had the final decisions about their own health care made by their husbands (Nepal Demographic and Health Survey, 2001).

Studies have suggested that male involvement in maternal health services results into positive outcome for not only the pregnant woman but also for the unborn child. Reporting findings of their studies Pagel et al., (1990) and Mutale et al., (1991) concluded that lack of social support; especially from the husbands or from family has negative effects on fetal growth. However despite these benefits of male involvement in maternal health care services, the majority of interventions and services to promote SRH including care during pregnancy and child birth in most countries have been exclusively focused on women (Ntabona, 2002). Yet it is important to assume that for all the steps leading to maternal survival there is always a man standing by the side of every woman knocking at the gate, before, during and after each pregnancy (WHO, 1995). Although few would now disagree that men's involvement is important, the introduction of programs that aim to involve men pose some serious questions about the effects of involving men in areas that have traditionally been considered the preserve of women, such as child care, pregnancy and fertility control (Berer, 1996, Helzner, 1996).

Moreover, studies have shown that men who are educated about reproductive health issues are more likely to support their partners in contraceptive use, use contraception themselves, and demonstrate greater responsibility for their children (Grady et al, 1996). More importantly, women express great interest in wanting their partners to be involved in joint reproductive health decision – making. For example, a study in Ecuador surprisingly showed that 89% of women wanted their partner to accompany them on their next family planning visit and 94% would have liked their partners to be present during their family planning session (Melita, 2002).

2.4 Levels of male involvement between ANC and PNC Services

Educational interventions for pregnancy health have traditionally been inadequate in addressing a man's degree of influence within the household on health-related decisions. About 210 million women become pregnant each year with 30 million (15%) developing complications resulting into over half a million maternal deaths due to low male involvement (WHO, 2005). Developing countries account for more than 99% of all maternal deaths; about a half occurring in sub Saharan Africa, and a third in South Asia, (UNICEF, 2008). Observational studies have shown that educating men about the importance of health care for the family increases the promotion of some health-seeking behaviors, such as antenatal care (ANC), postnatal care (PNC) and child immunizations (Johansson et al, 1998). Health seeking behaviors enhances communication and

support of female partners. Involving men in ANC and PNC services will be important to achieving Zambia's Millennium Development Goals. Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behavior. Comprehensive male involvement includes; encouraging men to become more involved and supportive of women's needs, choices, and rights in sexual and reproductive health; and addressing men's sexual and reproductive health needs and behavior.

A study conducted in Maharashtra in India found that majority of husbands in the state accompany their wives for their first check up to confirm pregnancy; but the women generally went alone or with the other female members of the family for subsequent visits (Barua, 1998). The study also found that husbands ignore wives' health care during pregnancy, except for the awareness for the need for antenatal registration and a nutritious diet. Delivery and post-delivery periods were found to be exclusively women's affairs.

2.5 Factors affecting male involvement in ANC and PNC Services

Poor women in low and middle income countries have many responsibilities. Besides caring for their children, they are expected to work hard preparing food, fetching water or tending crops. Many live long way from their nearest health facilities and have little access to transport. It is therefore hardly surprising that a third of the world's pregnant women do not attend antenatal clinics (WHO, 2005). Yet, women's ability to seek health education interventions is often determined by the house hold head, usually the husband.

The International Conference on Population and Development (ICPD) in 1994 called on organizations that historically had provided family planning and other reproductive health services to women to constructively involve men in their programs for the benefit of both men and women's health. Advocates and feminists initially asked whether involving men risked delivery resources from women and encroached on their reproductive freedom. These concerns, however, have lessened with the growing recognition, spurred on by the HIV epidemic that the reproductive health of individuals largely depends on a relational act occurring between two married people. Considering these relationships as central to reproductive health programs are now generally recognized as useful and necessary (UNAIDS 2004). Involving men often like

including them in counseling sessions, either alone or with their female partners during antenatal and postnatal clinic is important.

According to Raju and Leonard as quoted by Bloom et al., (2001) the process of bringing men needs to be carefully considered so that in no way are we undermining the often precarious rights of women to control their own bodies and make their own decisions. If men participate because of a demand from women, then we will see a shift in the social construct that is being spearheaded by women themselves (Ibid).

A number of factors have been reported by several researchers as being responsible for influencing male involvement in antenatal and postnatal care services. Traditionally, health providers and researchers in the field of reproductive health have focused almost exclusively on women when planning programmes and services, especially with regard to Family Planning (FP) prevention of unwanted pregnancies and of unsafe abortions, and promotion of safe motherhood (WHO, 2001).

However for purpose of this discussion, factors affecting male involvement in ANC and PNC services were considered under the following categories; cultural factors, socio-economic factors, health service associated factors, communicable factors and attitudes/ perception and the traditional myths.

Cultural factors: Men do not seek health information and services due to traditional notions of masculinity, where asking for help from a health provider is viewed as a sign of weakness. It is not uncommon in most African societies for men to decide as to when and how a woman should seek care. For example a study done in Kano Nigeria, shows that 17.2% women did not attend regular ANC because of husband denial (Adamu and Salihu, 2002). In Uganda, despite health facilities being in walk able distances in many districts, women having income and improvement in the quality of care, women continue to report late for ANC and deliver outside the health facilities (Kasolo and Ampaire, 2000). This fact of male's affecting utilization of ANC and PNC services in Uganda is supported by the findings of the study done by Nyane (2007) in Toronto in which she observed that some pregnant women when asked to come with their partners during the next ANC visit dropped out. A study done among Garo people of India revealed that cultural

beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities (Nyamongo, 2003).

Socio-economic; Some men feel it is a duty to facilitate their wives in terms of transport and if they do not have means of transport they see no point in escorting them while both of them are walking. Thaddeus and Maine (1994) illuminated that long distance to a health facility is one of the most important determinants in the decision not to seek modern health care even when needed. Yet in many situations in Zambia where the man is economically in position to provide the basic necessities of life, he tends to have more than one wife, which also negatively affects his willingness and ability to escort the wife to seek care (Example, amongst the Tongas of Southern Province and the Mambwes of the Muchinga Province of Zambia). Multiple partner relationships promotes different interests for the man and his partners and this will hamper possibilities for transparent in decision making in health related issues. Reporting his findings, Ratcliffe (2001) as quoted in Nyane (2007) noted that men are often involved in multiple sexual relationships that present a considerable challenge to fertility awareness and reproductive health programmes.

Health Service Associated Factors; Generally research shows that service related factors are more important than user related factors in affecting male involvement in ANC and PNC services. The most important ones pointed out 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 behavior from service providers is also a challenge. Harsh, critical behavior and language from skilled health professionals is a barrier to male participation and discourages men from returning or participating in maternal health care activities.

Quality of care at health centers are at times pose challenges in male involvement in health related issues. Health services providers are often overworked stressed and have to work in infrastructure with severely limited resources. In such context, the quality of services is compromised and taking care of male partners is considered an additional burden (Ntabona 2002). Clinics are often unable to concurrently accommodate pregnant women with their partners because of lack of space/resources. When there is limited physical space to accommodate male partners they are not comfortable and this can add to the burden and stress of

the health providers. While a study done in Turkey shows that health workers were not supporting men who sought to join in maternal health services, the same study noted that a lot of men come to the clinic with their wives but it stops at the door (Cigdem et al, 1999). In their study Bulut and Molzan (1995) noted that long working hours and difficult in taking off work to attend health services was a challenge to men.

Attitudes/Perception and myths: Negative attitudes of men and women that most of the health providers in the health facilities are women, hinders male 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 leads to low male involvement in maternal health services because maternity wards are treated to be for women who are in labour. The traditional practice of young women going to their natal homes for maternity discourages male participation in health issues. There is a strong belief in this society that a man is not supposed to witness the birth of the child, if he does so he can lose that strength. Reporting the findings in the study done in South Africa by Mullick (2005) revealed that some health care workers are so much attached to the idea that maternal health service is for women such that do not have an initiative to involve husbands in the care of their wives.

Supervision reports by Mulley (2000) reveal various reasons for low male involvement in health services. Part of the reasons for the low male involvement has come a long way with the traditional attitude of health workers, coupled with notices in the health care premises, for example, men are not allowed in the labor ward which discourages the men from giving support to their wives in Antenatal care and labor. Other reasons cited for low male participation in Antenatal care services are social stigma, shyness, embarrassment and job responsibility.

The findings of another study showed that most men in Pakistan (Pindu) have minimal knowledge of risks of symptoms of danger in pregnancy (Hafeezi, 1998). The study further reveals that a set of gendered beliefs that excludes men from women's pregnancy related domain defines the physiological process for reproduction as "napaak" (meaning unclean) for 40 days in the post- partum period. Taken together those gendered norms, values and beliefs mean that men are largely excluded from women's pregnancy-related issues. With the view that most health care providers are women, the findings have shown that service provider's attitudes also play a significant role. Whilst health care providers have been receptive to men's participation in

antenatal and postnatal clinics, they have prohibited men's entry into the labor wards (Kunene et al., 2004). These findings concur with the assumptions made by Moses (1993) that reproductive work is almost always the responsibility of women and girls. The findings of the study however, demonstrate that the issues surrounding women's uptake of ANC and PNC are much more complex than availability of services alone.

A study from Kenya revealed that where women are supported and accompanied by their male partners, they are more likely to consistently visit antenatal clinics (Irin plus News, 2009). The study also revealed that few men usually accompany their wives on visits to antenatal clinics for fear of being ridiculed by peers (Martin et al., 2007). However, it has been shown that when male partners are involved, both partners can get tested for HIV, know their status and therefore improve the baby's chances of healthy survival. The findings of the study indicate that promotion of programmes aimed at increasing male attendance in ANC could function to reduce the risk of vertical transmission and infant mortality. The government is considering various incentives, such as waiving maternity fees, to boost male participation in ANC (Winkvist 2004). Antenatal care counseling could improve mother's awareness and knowledge of the importance and the availability of postnatal care services (York et al., 2000).

Many studies have shown positive health effects when male partners or husbands have attended health education or counselling sessions on HIV/AIDS, prevention, family planning, ante-natal and post-natal care, and nutrition values. Randomized trials in Turkey, Ethiopia, and China have found that contraception adoption was significantly higher among women whose husbands were included in contraceptive counseling compared to women whose husbands were not involved (Fisek&Simbuloly, 1994). A study by Winkvist (2004) on the impact of involving ante-natal education to prospective fathers in India found a significantly higher frequency of ante-natal clinic visits and lower peri-natal mortality among the women whose husbands received ante-natal education

Communication; Communicating with men has been reported by some researchers to pose daunting challenges for programmes, which historically have focused on serving women (Young and Kol, 1999). It is not easy to design messages and materials that men find persuasive, but that also promote gender equality and women empowerment. In a study done by Young and Kol (1999) noted that, in Zimbabwe, most men misinterpreted campaign messages promoting male

involvement to mean that decisions should solely be left to men. Sometimes couple dialogue may be the problem, once there is a communication breakdown for one reason or the other, the whole family function fails. Kasolo and Ampaire (2000), in their research highlighted an example of a breakdown in communication among couples where they reported that some men did not want to discuss ANC attendance with pregnant women because they considered them to nag a lot.

2.6 Differentials of male involvement in ANC and PNC Services

A study done in Malawi shows that knowledge of pregnancy complications among male partners varies by residence. According to 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%. In general, knowledge of pregnancy complications among men in the most urbanized districts of Malawi is limited (MDHS, 2004). Few men in Blantyre and Lilongwe know about high fever, and only 3% know about prolonged labour. Knowledge of pregnancy complications is much higher in less urbanized district like Thyolo and Mulanje districts.

A study from Nepal in India shows that husband's involvement in the prevention of ill maternal health during pregnancy and delivery was a vital contribution to reduce maternal morbidity. It was noted that husbands provided supports such as fetching water, bringing nutritious food, arranging and accompanying their wives to prenatal and postnatal care visits advising their pregnant wives not to carry heavy loads and providing money for transport and medical costs (Groenewold et al, 2004).

At the same time, the historic focus of services on women has led to neglect of men's need for reproductive health information and services, often to the disadvantage of both men and women. Men are often less knowledgeable about anatomy and physiology of their bodies than women in many rural settings. As found by Cadwell (1979) in many countries, infants born in rural areas consistently had higher odds for not using health care services, which might be due to the lack of the services or reduced access to health care services from the inadequate transportation infrastructure. A study done in Bla Mali by Meckonnen and Meckonnen (2002) shows that women's use of care tends to be further restricted by educational, social, cultural, and financial

factors. Several studies in Mali have pointed to a very low or inadequate use of appropriate maternal care services (Owino 2001; Moore 2000).

A study which was done by Johns Hopkins University on male involvement in antenatal and postnatal clinics shows a review of 20 men's family planning programmes from Africa, Asia and Latin America. Their reports found that contrary to what some supposed, many men wanted to be involved in family planning programmes and that in those programmes in which men were viewed as caring partners rather than as irresponsible advisors were successful in involving men (Johns Hopkins School of Public Health, 1997).

A study done by AVSC International presented findings from the eight family planning clinics that they had run in Colombia since 1985 (AVSC International, 1985). The study found that clinics were successful in attracting male clients. AVSC attributed this success to their policy of offering a brief counselling session to help men articulate their needs and talk about their doubts before they attend medical consultations. Another important element cited by the report was the policy of encouraging couples to seek ANC and PNC services together.

In Honduras, a study conducted by Population Council reported on a programme designed to increase men's knowledge of family planning and to facilitate their role in reproductive decision making (Population Council, 1998). In this study, two strategies were used; one involved agricultural extension workers who were trained to give health education sessions based on a training manual, and the second extended in agricultural program, the farm management plan into areas of family planning through the use of family planning management booklet. The program managed to involve men through low-cost strategies that were incorporated into already existing structures (Population Council, 1998).

A study done in Nepal in South Asia shows that maternal mortality is estimated to be around 540 deaths per 100,000 births (Asian Development Bank, 1999). One identified major factor for this high rate is low male involvement despite government efforts to improve services, including an expanded network of rural clinics and the training of auxiliary nurse midwives (Asian Development Bank, 1999).

2.7 Summary of the chapter

The studies reviewed have demonstrated that firstly, knowledge and attitudes of people on ANC and PNC services is still a problem and the role of the male partner is a key contributor to community acceptance and support of ANC and PNC services. Secondly, male involvement needs to be comprehensive in terms of establishing friendly health facilities. The contradiction between men's beneficial attitudes towards their partner's needs should be more specifically addressed in ANC and PNC services. There are communication barriers between pregnant women and their husbands/partner is not supportive generally. For safety and acceptability of ANC interventions it is essential that effective steps be taken to combat the negative attitudes.

CHAPTER THREE

METHODOLOGY OF THE STUDY

3.0 Introduction

This chapter discusses the research methodology used in the study. The choice of the research method has been described. This includes the research design, target population, sample size, sampling procedure, research instruments, data collection and data analysis procedures. Finally, aspects concerning reliability, validity and research ethics for this study have also been discussed.

3.1 Research Design

According to Yin (1994:19), a research design is “*an action plan for getting from here and there.*” He further describes a research design as a “*blueprint*” of the research, which deals with four problems: (I) what question to study, (ii) what data is relevant, (iii) what data to collect, and (1v) how to analyze the results. This research used a case study design based on the research questions posed which mostly answered the “what” questions. Yin (2003) holds that the use of a case study does not only enable the researcher to arrive at an in-depth analysis and logical explanation of contemporary events, but also helps in yielding qualitative data from one locality. Furthermore, Kirk and Miller (1986) suggest that qualitative research is a particular tradition in social science, which depends on watching people in their own territory. In this study the researcher mainly used both descriptive and explanatory paradigms.

3.2 Research Methods and Instruments

The general research protocol for this study involved both primary and secondary approaches to data collection. The researcher identified the appropriateness of different methods in the investigation of relevant issues. In this study, data were collected by using five techniques, which were:

- i. interviews;
- ii. Focus Group Discussions;
- iii. Health Centers observations;
- iv. Document analysis
- v. Questionnaires

The research techniques listed above imply that the researcher applied multiple sources of data collection. This process is referred to as “triangulation” and the main purpose of this method is to validate the collected data (Patton, 1990; Yin, 1994; Gall et al. 1996). Furthermore, Patton (1990) supports the triangulation method that multiple sources of information are sought and used because no single source of information collection can be trusted to provide a comprehensive perspective on the programme. By using a combination of data collecting strategies, the researcher is able to use different data sources to validate and crosscheck findings since each type and source of data collecting strategy has strengths and weakness.

3.2.1 Interviews

An interview is a way of collecting data about a person by asking them rather than by watching their behaviour. It is an interaction or conversation that takes place between the researcher and a respondent in the process of data collection (Chilisa and Preece, 2005). Personal interview helps the researcher to measure what a person knows, thinks about a particular issue, and likes or dislikes. The researcher asked the respondents questions that are important to the study. To collect information from this study, interviews were conducted with stake holders who are usually referred to as providers.

The researcher conducted in-depth individual interviews with key informants in the provision of health services. The researcher used semi-structured thematic interviews with MCH coordinators, Clinical officers, Sisters in charge and officials in the Ministry of Health in Kabwe district and the few male spouses, as they could not form focus groups. The main research tool used in this case was an interview guide. Patton (1990) states that the interview guide provides topics or subjects’ areas within which the interviewer is free to explore, probe, and ask questions that will help to elucidate and illuminate that particular subject. Thus, the interviewer remains free to build a conversation within a particular area, to add questions spontaneously, and to establish a conversation style but with focus on a particular subject that has been predetermined. The researcher asked the respondents questions that were important to the study. To collect information for this study, interviews were conducted to stakeholders who are usually referred to as providers. Nevertheless, the interview guide failed to fully obtain the required information. This was because in some cases, the respondents especially ministry of health officials avoided

some of the questions diplomatically. Since the researcher could not force the respondents to give certain responses the researcher accepted whatever response was given.

3.2.2 Focus Group Discussions

In this study, Focus Group Discussions were also conducted using a guide with questions based on the study. According to Patton (1990), the use of interview guides is seen as important in order to assure that the same categories of information are obtained from a number of people about the phenomenon being studied. Largely, four Focus Group Discussions were conducted (two in urban areas and two in rural areas) with the smallest group having eight participants and the biggest group had a 15 participants. The two Focus Group Discussions conducted were exclusively for women while the other two were for men only. This was done in order to encourage free participation among participants of the same sex.

3.2.3 Health Center Observations

The researcher conducted four health Centre observations. According to Yin (1994) field observations are conducted to serve as another source of evidence in the study. By using this technique, the researcher had an opportunity to interact with spouses seeking medical attention at the health centres and used this as a tool for data collection and data were made more reliable with observation variables. The observation variables were based on the descriptive practices in terms of male involvement, richness of the environment (age, status, communication between health users, health providers and the sitting arrangement in the treatment room and other variables).

3.2.4 Questionnaire

A Questionnaire is a research instrument consisting of a series of questions and other prompts for the purpose of gathering information from respondents (Popper, 1959). A questionnaire is divided into sections starts with background information, main body and the conclusion. Questionnaires have advantages over some other types of surveys in that they are cheap, do not require as much effort from the questioner as verbal or telephone surveys and often have standardized answers that make it simple to compile data. Popper also holds that distinction is made between open-ended and closed-ended questions. Popper holds that an open-ended question asks the respondent to formulate his own answer, where as a closed-ended question has the respondent pick an answer from a given number of options. The response options for a closed-ended question should be exhaustive and mutually exclusive. Popper further argues that

however, questionnaires are sharply limited by the fact that respondents must be able to read the questions and respond to them (Popper, 1959). In this study 220 copies of questionnaires were distributed to the respondents and only 10 copies were discarded.

3.2.5 Document analysis

In this study, various documentary materials were used such as Zambia Demographic and Health Survey (CSO et al, 2007) Objectives and Strategies, Ministry of Health (2010), Ministry of Health Report (2008) and National Health Guide Lines (2012) were used. The idea was to collect information from, as many different sources as possible, then be able to counter check the information further to validate the findings, and help strengthen the study. As Weiss (1998) believes, documents are a good place to search for answers. They provide a useful check on information gathered in an interview. He further contends that when other techniques fail to resolve a question, documentary evidence can provide a convincing answer. Hamersley and Atkinson (1995) also share a similar view about documentary evidence that it would be hard to conceive of anything approaching ethnographic account without some attention to documentary material in use.

3.3 Geographical Position of Study Site

Kabwe district is located in the Central province of Zambia. It is surrounded by Kapiri mposhi in the North and Chibombo in the South respectively. It further lies in the middle veld with average altitude of 1207 meters, located between latitude 14° 27' South and longitude 28° 27' east on central plateau (Kabwe Municipal Council, 2010). The study was carried out in Kabwe district which is the provincial headquarters of Central province of Zambia covering total area of 94,394 square kilometers. The study was carried out in both rural and urban areas. Kabwe district covers a surface area of 1,572 square kilometers while Chibombo district covers a surface area of 13,423 square kilometers (Ministry of Health Report, 2008). The projected population for Chibombo district without AIDS is 407,752 while with AIDS is 395,397 by 2015. The projected population for Kabwe without AIDS is 260,360, While with AIDS is 236,706 by 2015 (CSO Report, 2000). Maternal health care services in the Kabwe district are delivered through a network total of twenty nine (29) health units of which four (4) are run by Ministry of Home Affairs and another four (4) are run by Ministry of Defense, while twenty one (21) are government run. The district has two (2) referral hospitals these are Kabwe General Hospital and Kabwe Mine Hospital (Ministry Of Health Report, 2008). According to the Ministry of Health

Report (2008) in Kabwe district, maternal health care services especially antenatal, delivery and postnatal care services are available from 29 health centers and two (2) regional referral Hospitals (Mine Hospital and Kabwe General Hospital).

3.4 Study Variables

3.4.1 Dependent Variables

The dependent variables were , men accompanied the wife to the health unit for antenatal delivery and postnatal during the most recent or a joint couple decision was made on where the wife is to attend ANC, delivery and postnatal care during the most recent or current pregnancy.

3.4.2 Independent variables

The independent variables included socio-economic and demographic characteristics of male respondents; these were age of the couples, education level of the respondents, employment status, marriage relationship, availability of means of transport, number of children a man has, having a radio or a TV in the home stead and the distance to the health unit from the man's home stead. Man's knowledge on maternal health services. This was the man's awareness of the recommended ANC visit for the pregnant woman during the course of pregnancy, services offered at health unit during ANC, delivery and postnatal care. Attitude men have towards maternal health services, especially health workers behaviour, quality of services offered and accessibility of maternal health services. Cultural factors, these were cultural factors that could be prohibiting male involvement in ANC and PNC and inter spouse communication. Others were; attitude of health providers to the clients, contraceptive utilization, travelling time, cost of service, parity, lack of privacy and local beliefs.

3.5 Target Population

Zikmund (2000) defines a target population as a specific sample group relevant to the research project. Oliver and Abel (2003) hold that target population is all members of any well defined class of people, events or objects who are designated as being the focus of an investigation. It can also be referred to as an entire group of persons or elements that have at least one thing in common. For the purpose of this study, the target population included all adults aged 18 and above participating in maternal health services (ANC and PNC services) in 32 centres in Kabwe urban and Chamuka areas, respectively. However, Clinical officers, Sisters-in-charge, MCH

coordinators and officials from the Ministry of Health were also targeted as informants since they were all stakeholders in the delivery of health services.

3.6 Sample Size and Sampling Procedures.

Sample size is defined as a piece or segment which is representative of the whole. It is a subset of a population consisting of characteristics in which a researcher is interested (Ngoma, 2005). Sampling is the process of selecting a sample or small proportion that is representative of the population for observation and analysis (Sidhu, 2006). Sampling procedures may refer to the part of the research plan which shows how cases were to be selected for the purpose of observation. Orodho and Kombo (2002) hold that sampling procedure is the procedure a researcher uses to gather people, places or things to study.

For quantitative approach, the sample for the study was drawn from two study areas, 98 respondents in Kabwe (50 males and 48 females) and 112 respondents in Chamuka area (72 males and 40 females). These sites were randomly selected for every second house hold for their differences in geographical location. Chamuka area is a rural area while Kabwe urban is an urban area. There were 220 respondents. Qualitative approach was purposively selected these included four (4) FGDs, 3 MCH coordinators, 2 Sisters in charge, 3 Clinical officers and 2 health officials in the ministry of Health in Kabwe district. However, single parents and females who were pregnant or had a child but were not married were excluded from the study. The study population comprised of all men and women of 18 years of age and above and who had lived for more than 12 months in that study area preceding the study.

3.7 Sampling Techniques

The issue of sampling anchors on all the health services users and the health service providers who included participants, MCH coordinators, Clinical officers Sisters-in-charge and health officials in the Ministry of health in Kabwe district as indicated in 3.6. The centres were purposively selected because they should have specific respondents to illuminate key issues and concerns. The purposive sampling was used in order to achieve a rich and varied collection of information. According to Patton (1990), purposive sampling involving the selection of information-rich cases whose study will elucidate answers to the question under study. He holds that the logic and power of logic purposive sampling lie in selecting information-rich cases for

the in depth study. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research.

Due to the limitations as indicated in chapter four, the accessible population was purposively sampled from rural and urban areas which were good information basis for the study. These locations selected should not have been in hard-to-reach areas. This is in line with Gosh (2006) who says purposive sampling is used when the universe is not defined and when administrative limitations make it difficult for the researcher randomly to select samples. In this regard, data collection in any other areas would have required the assistance of an interpreter. These areas were purposively chosen because the researcher was conversant with the language spoken in this area and also he understood the cultural and social aspects in the studied areas.

3.8 Data Collection Process

The process by which data is processed and converted into meaningful statements is referred to as data interpretation (Gosh, 1992; Sarantakes, 1993). The purpose of data analysis was to process raw data for interpretation. The researcher conducted an initial “reconnaissance” exercise in both areas to locate specific centres at which the study might be carried out, identify centre administrators, and obtain consent for the study. As indicated in 3.6, the study used multiple sources of inquiry (Triangulation). The underlying principle behind this was that this technique offered the opportunity to address the issue efficiently. The most significant advantage presented by the use of multiple sources of inquiry was the development of converging lines of inquiry and this increased the validity, quality and reliability of the findings. Data collection was done with the aid of a tape-recorder and field-notes. In order to conform to the antenatal and postnatal care services calendar, the collection of data was done on Mondays and Thursdays of every week. These days were appropriate because it is when the centres recruited new couples for the first antenatal and postnatal care bookings.

3.9 Data Processing and Analysis

This study took both qualitative and quantitative paradigms. This means that for qualitative data analysis (particularly preprocessing) begun at the onset of the data collection stage. According to Hamersley and Atkinson (1995) in analyzing qualitative data, the initial task is to find concepts that help make sense of what is going on. He further suggests that these concepts about data analysis start arising during data collection and that marks the beginning of the analysis and this

continues throughout the study. This study also used the method of inductive analysis as the basis for its analysis. Patton (1990) holds that the strategy of inductive design is to allow the important analysis dimensions to emerge from patterns in the cases under study without presupposing in advance, what the important dimension will be.

In this study, constructs, themes, and patterns were elicited from the interviews and Health centre observations with the aim of using them in the description of the phenomenon being studied (Gall et al., 1996). In this scenario, data preparation included transcribing interviews, summarizing and organizing of data according to themes and categories. This is because there are no hypotheses before the data collection. The understanding of the phenomenon under study and outcomes emerge from experience with the setting and theories. What is happening in a setting is grounded in direct programme experience rather than imposed on the setting (Patton, 1990; Silverman, 2000).

Quantitative data is the data that can be quantified and verified, and is amenable to statistical manipulation. According to Given (2008) quantitative data is a systematic approach to investigations during which numerical data is collected and/or the researcher transforms what is collected or observed into numerical data. In layman's terms, this means that quantitative research asks a specific, narrow question and collects numerical data from participants to answer questions. Therefore, in this study questionnaires were used to collect quantitative data from respondents. The computer software Statistical Packaging for Social Science (SPSS version 16.0) was used for processing and analyzing quantitative data. Descriptive statistics were applied to the processed data by showing variable frequency distribution.

3.10 Delimitations

The study was limited by its catchment area because it was conducted specifically in two different settings. Another limitation of this research was related to methodology, as the sample size drawn from Kabwe urban and Chamuka area was too small to be a representative sample of the whole population of Zambia. Furthermore, considering the fact that it was a case study to generalize the findings would be limited due to Hawthorn effect (that is replication of responses from the participants).

3.11 Challenges

Since the research was done in 2012, a year after the Presidential and General Elections were conducted, some respondents were not willing to participate in the exercise due to political fatigue. In this respect, they paid more allegiance to the researchers and politicians who were able to offer money, a factor that was beyond the financial range of the researcher. Worse still, some of the respondents were reticent (not willing to speak). It could be that they might have been fatigued by a number of previous researchers and were unwilling to participate in any other research. To overcome this hurdle the researcher had to spend time on persuading the respondents and more money on making more call backs.

Another limitation to the study is reporting bias arising from participants wanting to provide socially desirable responses rather than a true reflection of the real life situation. Participants especially in focus group discussions may have been uncomfortable to share all information for fear of peer pressure resulting in incomplete information. The researcher attempted to address these constraints by using two different data collection methods, and in addition, took field notes on what was observed at the health facilities in relation to male involvement in the study area. This approach enabled the researcher to have a deeper understanding of male involvement in the study area, by bringing together what respondents said and what they actually do.

3.12 Reflections on Ethical Issues

In order to adhere to Research principles, aspects related to ethical issues were taken into account during data collection. It was expected that the researcher would uphold the research ethics. When the researcher arrived at every site of study, he sought permission from centre authorities to conduct research there. He further briefed them on the value of the research and the procedures to be used. The researcher also assured the administrators that participation by health staff and respondents was voluntary; hence the requirement for filling in Informed consent forms. Participants were not coerced if unwilling to participate in this study. As a way of maintaining privacy and confidentiality, no authentic names have been mentioned but rather pseudo names have been used where necessary. Furthermore, participants were assured that the data to be obtained would not be disclosed to any other persons. In respecting the research site, the researcher ensured minimum disruption of the smooth running of the centres visited. Finally, the researcher took full responsibility for the conduct of the study and as far as foreseeable, its consequences.

3.13 Summary of the chapter

The chapter focused on the methodology that was used to generate data from the respondents. It discussed methodological aspects that were key factors to the collection and processing of data of this study. Aspects concerning reliability, validity and research ethics for this study were also discussed.

The next chapter will present the salient key findings of the study.

CHAPTER FOUR

STUDY FINDINGS

4.0 Over view

The chapter presents findings on factors affecting male involvement in antenatal and postnatal care services in Kabwe urban and Chamuka area. In this chapter, subheadings derived from the study objectives and research questions were used to present the findings of the study.

4.1 Introduction

Findings were obtained using questionnaires, interviews, documentary, FGDs and observations. The results of the study were presented under subheadings derived from the study objectives and research questions. Quantitative data were obtained using questionnaires from which tables, percentages and graphs were generated. Qualitative data obtained from interviews, documentary, observations and FGDs were analyzed by coding and categorizing the emerging themes and subtitles accordingly. The findings are presented under the headings below.

4.2 Socio-Demographic background

4.2.1 Sex

The gender of respondents was important in coming up with appropriate methods to use in the delivery of an improved version of involving men in antenatal and postnatal care services.

In terms of sex distribution, respondents from this study were primarily males (58.1%, n= 122). Most of these respondents were from rural areas (64.3%, n= 72). The female respondents were 41.9 %, n =88. Most of the female respondents were from urban area (49%, n = 48)

Table 4.1: gender of respondents

Background Characteristics	Urban		Rural		Total	
	<i>Count</i>	<i>Percent</i>	<i>Count</i>	<i>Percent</i>	<i>Count</i>	<i>Percent</i>
Sex						
Male	50	51	72	64.3	122	58.1
Female	48	49	40	35.7	88	41.9
Total	98	100	112	100	210	100

Source: Field Data, 2012.

4.2.2 Age

Table 2 below indicates that most of the respondents in this study were in age group of 35-39 (22.4%, n =47). Most of these respondents were from rural areas (23.2%, n =26). This was followed by respondents from age group between 30 and 34 (21.4%, n =45), and most of these respondents were from urban area (25.5%, n =25). This age group is the most active in terms of child bearing because it has high fertility levels. However, the table further shows the drastic decline in fertility between age group 45-49 (8.6%, n=18) respectively, as the ages of the respondents draw closer to menopause. Only 7 (3.3%) of the respondents in this study group were in the adolescent age group between 15 and 19. The percentage of this age group is the lowest because respondents in this age group are still attending schools and they are not yet active in marriage issue. Age group in this study is an important demographic background characteristics because it determines the fertility levels in female spouses who are in fecundity. However, marriage at a very young age is the major reason for early pregnancies in Zambia. The information on age was crucial in coming up with strategies of involving men in maternal health services that would cater for all age groups in the study area.

Table 4.2: Age of Respondents.

Source: Field Data, 2012.

Background Characteristics	Urban		Rural	
	Count	Percent	Count	Percent
15-19	6	6.1	1	0.9
20-24	7	7.1	8	7.1
25-29	16	16.3	24	21.4
30-34	25	25.5	20	21.4
35-39	21	21.4	26	23.2
40-44	19	19.4	16	14.3
45-49	4	4.1	14	12.5
Total	98	100	109	80.7

4.2.3 Marital Status

In terms of marital status by sex, 91.9 percent of the respondents at the time of study were married, and most of the respondents were from urban area (92.9). The proportion of married persons is one of important parameters in determining the quality of health service offered to the mothers and their babies. Studies reveal that married couples are more likely to provide better care to young ones than the single divorced and the widowed. Marital status in this study of male involvement in antenatal and postnatal care services is one of the eligibility criteria used to recruit respondents in the study.

Table 4.3: Marital status of Respondents.

Back ground Characteristics		Married	Single	Divorced	Separated
Urban	Count	91	5	2	0
	Percent	92.9	5.1	2.0	0
Rural	Count	102	9	1	0
	Percent	91.1	8.0	0.9	0
Total	Count	193	14	3	0
	Percent	91.9	6.7	1.4	0

Source: Field Data, 2012.

4.2.4 Education

Table 4 below shows that most of the respondents in this study had tertiary education (70.4, n= 69) and were from urban areas (70.4, n=69), while respondents from rural areas who had tertiary education were representing 13.4%, n=15. About 34.3% of the respondents had Secondary education and were mainly from rural areas (41.1, n=46) while the respondents from urban areas were only 26.5%, n=26. For the primary sector they were only 3.2%, n=7 of the respondents who had primary education and were all from rural areas (6.2%, n=7).

Studies have shown that educated women are more likely to discuss and make joint discussions with their spouses on pregnancy health issues than uneducated (Britta et al, 2004). Educational attainment is generally one of the key indicators for analyzing women's status. International Labor Organization states that large educational differentials between men and women tend to sustain a perpetual gender inequality within the family and in society at large (ILO, 1995).

Compared to women of low literacy level, educated women bear fewer children and achieve better child survival, because they avoid early marriages, teenage pregnancies, and high parity because they attend antenatal and postnatal more frequently. A study done in Kwale district, Kenya revealed that women with secondary education or above were more likely to attend for antenatal care (Brown et al, 2008). The same study also highlighted the relationship between antenatal and good peri-natal out comes. Women should be educated on sex, pregnancy and contraceptive use early in life as this would help them make informed decision later on in life (Ehlers, 2008).

Education attainment is generally associated with improved socio-economic status. Educational attainment goes along with a number of benefits and is one of the aspects that bring inequality in any society. Education provides individuals or society opportunities to improve their living standards, and quality of life. Education, particularly education of girls and women greatly enhances the ability of households to manage health problems, improve nutrition, ensure more effective diagnosis and demand timely treatment (Watkins, 1999).

Table 4.4: Educational attainment of Respondents.

Back ground Characteristics		None	Primary	Secondary	Tertiary
Urban	Count	0	3	26	69
	Percent	0	3.1	26.5	70.4
Rural	Count	7	44	46	15
	Percent	6.2	39.2	41.1	13.4
Total	Count	7	47	72	84
	Percent	3.2	22.4	34.3	40.0

Source: Field Data, 2012.

4.2.5 Economic activity

Tale5 below indicates that most of the respondents in this study were from self- employment sector (38.6%, n=81), and most of them were from rural areas (58.9%, n=66). This was followed by the respondents from public sector (36.6%, n=81), and most of them were from urban area (67.3%, n =66). Only 1.0 percent of the respondents in this study were unemployed. Economic activity is an important background factor in measuring the level of male involvement in maternal health care services because it shows the main sources of income of respondents in the

study area. With this view economic status of the respondents was vital as it would have an influence on the crusade of persuading male involvement in antenatal and postnatal care services.

Table 4.5: Economic activities of Respondents.

Back ground Characteristics		Public sector	Self employed	Unemployed	Home duties	Retired
Urban	Count	66	15	0	12	5
	Percent	67.3	15.3	0	12.2	5.1
Rural	Count	11	66	2	28	0.5
	Percent	9.8	58.9	1.8	25.0	4.5
Total	Count	77	81	2	40	10
	Percent	36.7	38.6	1.0	19	4.8

Source: Field Data, 2012.

4.2.6 Religion

The distribution of respondents by religious denomination reveals that a larger proportion (48.6 %, n =102) of the respondents in this study belonged to the protestant churches, and most of them were from rural areas (58.0%, n=65). While those claiming affiliation of the catholic and Moslem denomination accounted for 26.2 percent and 0.1 percent, respectively. Religious affiliation is an important back ground characteristic in this study because Religion helps to impart knowledge, morals and norms to society. For instance the Moslem society exhibit deficits and deprivation in practically all dimensions in the areas of female schooling and economic status. Studies from Pakistan and Bangladeshi observed that religion is an important prediction of demographic and health outcomes (Addai, 2000).

Evidence from Africa reflected that the high level of maternal health service utilization among women of certain religious groups could be attributed to life style and theological differences between different religions. Further, certain norms and characteristics of some religious groups may encourage negative attitudes towards modern medicines and health services utilization. This aspect to a great extent influences the level of male involvement in antenatal and postnatal care services in a society.

Table 4. 6: Religious Affiliation of Respondents.

Back ground Characteristics		Catholic	Protestant	Moslem
Urban	Count	28	37	1
	Percent	28.6	37	1.0
Rural	Count	27	65	1
	Percent	24.1	5.0	0.9
Total	Count	55	102	2
	Percent	26.2	48.6	1.0

Source: Field Data, 2012.

4.3 Recent maternal experience of participants

The study obtained information on the most recent maternal experience by asking men if they or their spouse had ever been pregnant in the five years preceding the study. It was revealed that 98% of the respondents from the rural areas and 72% from the urban areas reported that they had been pregnant before in past five years preceding the study. Overall, 86% of the respondents reported having been pregnant before in the five years preceding the study (Figure 4.1)

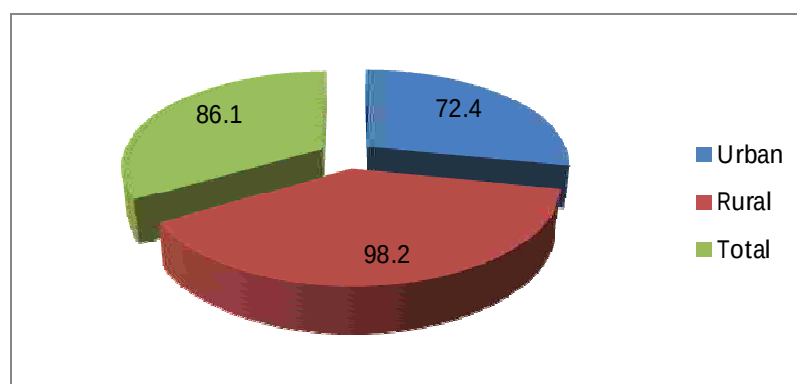


Figure 4.1: percent of respondents who had been pregnant in the last five years preceding the Study. Source: Field Data. 2012.

When asked whether respondents had ever visited the clinic for ANC services the last time they were pregnant, Figure 4.2 shows that 93.3% of respondents reported having visited the clinic for ANC services. Respondents from the urban areas were more likely to have visited the clinic for ANC services (96.9%) compared to the respondents from the rural areas (90%).

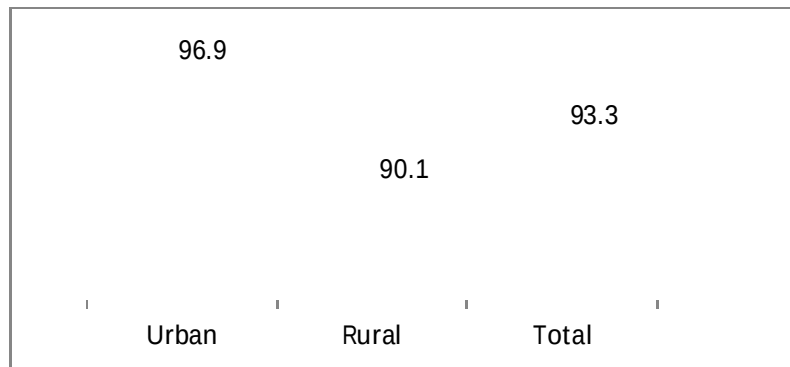


Figure 4.2: Percent distribution of respondents who ever visited the clinic for ANC services

Respondents were further asked to state if they had ever given birth in the past five years preceding the study. Results in Figure 4.3 shows that 84.8% of the respondents reported having given birth to a child in the last five years preceding the study. This varied by residence as respondents from the urban areas were more likely to have given birth (95.5%) than those from the rural areas (72.4%)

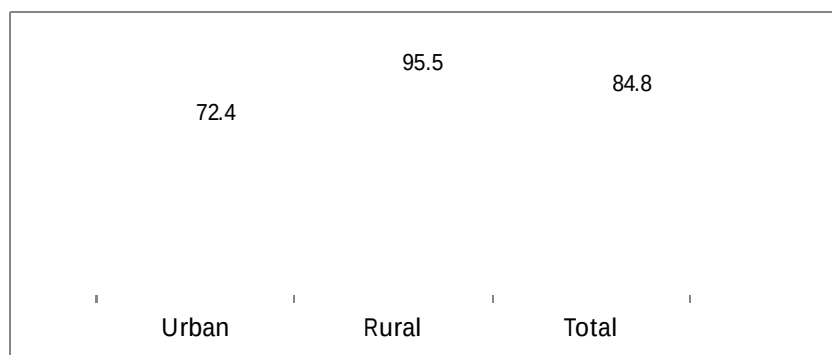


Figure 4.3: percent of respondents who have given birth in the last five years preceding the study. Source: Field Data, 2012

The study further found that among the respondents who had given birth in the past five years, 91.2% (93.4% from Kabwe rural and 88.8% from Kabwe urban) reported having visited the clinic for PNC services.

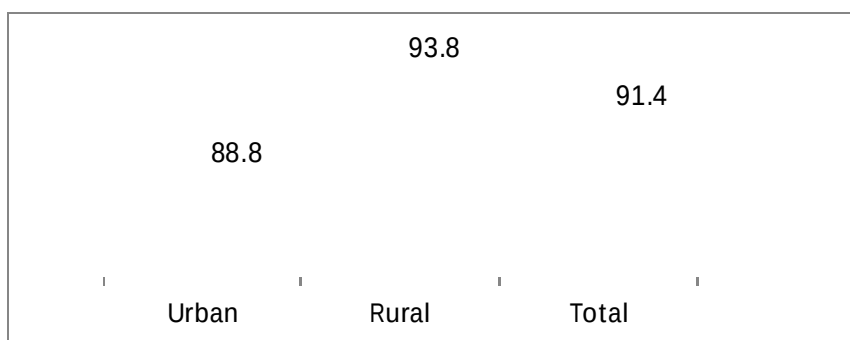


Figure 4.4: Percent distribution of respondents who have visited the clinic for PNC services

Source: Field Data, 2012.

4.4 Knowledge on ANC services

Respondents were asked whether they were aware of the ANC services at the clinic, 92.9% stated that they were aware of the services. The difference was very minimal by residence with the respondents from Kabwe urban being slightly more knowledgeable (93.9%) than those from Kabwe rural (92%) (figure 4.5).

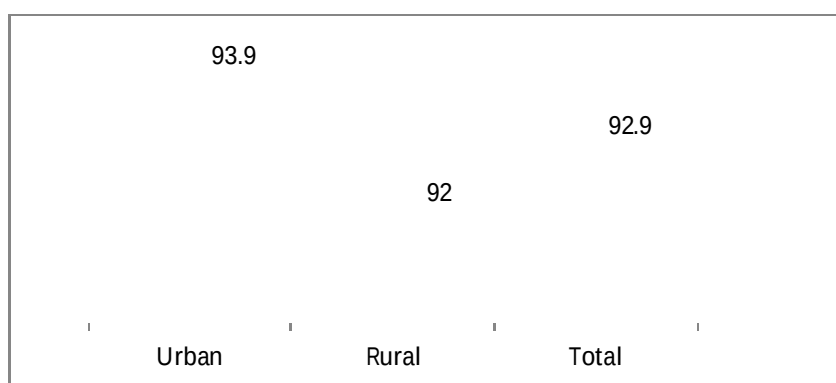


Figure 4.5: Knowledge on the existence of ANC services

4.5 Knowledge of PNC service

Figure 4.6 shows that 93% of the respondents were aware of the existence of PNC services at the clinic. The level of knowledge was more among respondents from Kabwe urban (96.2%) compared to the respondents in Kabwe rural (89.2%). The 7% of the respondents recorded with lack of knowledge of these services could be attributed by lack of sensitization and outreach to the communities.

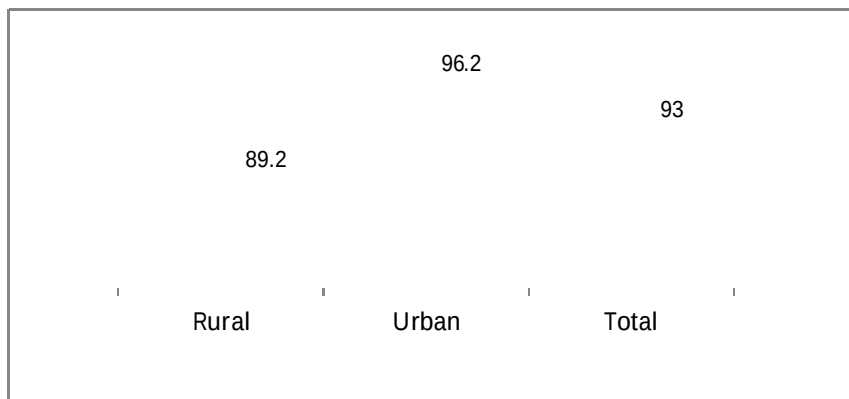


Figure 4.6: Knowledge on the existence of PNC services

Table 4.7: Residence and Knowledge on ANC services

ANC Services	Residential			Chi-Square Tests		
	Rural	Urban	Total	Pearson Chi-Square Value	df	Sig. (2-sided)
Family planning	50.8	49.2	183	4.00	1	0.046
Immunization	44.4	55.6	135	11.78	1	0.001
Vaccination	44.1	55.9	145	16.40	1	0.000
Birth preparedness	57.0	43.0	172	10.80	1	0.001
Health promotion	48.4	51.6	124	2.42	1	0.120
Early det. of complication & prompt of treat.	50.9	49.1	114	0.32	1	0.571
Counseling	53.8	46.2	171	0.87	1	0.352

The table above shows the frequency and percent distribution of respondents' residence and their knowledge on ANC services. The findings show that respondents in the rural areas were the majority (50.8 percent) in knowledge on family planning, knowledge on birth preparedness (57.0 percent), knowledge on early detection of complication and prompt treatment (50.9 percent) and knowledge on counselling (53.8 percent). Those in urban areas were minority in knowledge on family planning (49.2 percent), knowledge on birth preparedness (43.0 percent), knowledge on early detection of complication and prompt of treatment (49.1 percent) and lastly knowledge on counseling (46.2 percent). Respondents in urban areas were the majority (55.6 percent) in

knowledge on immunization, knowledge on vaccination (55.9 percent), and knowledge on health promotion (51.6 percent). Those respondents from rural areas were minority in knowledge on immunization (44.4 percent), knowledge on vaccination (44.1 percent) and knowledge on health promotion (48.4 percent).

The findings of the study show that there is no significant relationship between residence and respondents' knowledge on selected ANC services as shown by the chi square values and the p-values of greater than 0.05: health promotion ($X^2 = 2.42$, $P=0.120$), early detection of complications and prompt treatment ($X^2 = 0.32$, $P=0.571$) and counselling ($X^2 = 0.87$, $P=0.352$)

Furthermore, the findings show that, there is a significant relationship between residence and respondents' knowledge on selected ANC services as shown by the chi square values and the p-values of less than 0.05: family planning ($X^2 = 4.00$, $P=0.046$), immunization ($X^2 = 11.78$, $P=0.001$), vaccination ($X^2 = 16.40$, $P=0.000$) and birth preparedness ($X^2 = 10.80$, $P=0.001$).

Table 4. 8: Sex and Knowledge on ANC services

ANC Services	Sex		Chi-Square Tests			
	Male	Female	Pearson Value	Chi-Square	Df	Sig. (2-sided)
Family planning	92.8	95.5	0.66		1	0.417
Immunization	77.1	64.0	3.88		1	0.049
Vaccination	65.8	86.7	11.07		1	0.001
Birth preparedness	85.6	93.9	3.36		1	0.067
Health promotion	63.9	64.0	0.00		1	0.988
Early detection of complication and prompt of treatment	42.3	80.7	28.87		1	0.000
Counseling	83.8	94.0	4.72		1	0.030
Total	111	83				

The table shows the frequency and percent distribution of respondents' sex and their knowledge on ANC services. The findings show that female respondents were the majority (57.9 percent) in knowledge on family planning and 42.1 percent of male respondents know about family planning.

The findings show that, there is no significant relationship between respondents' sex and respondents' knowledge on selected ANC services as shown by the chi square values and the p-values of greater than 0.05: family planning ($X^2 = 0.66$, $P=0.417$), birth preparedness ($X^2 = 3.36$, $P=0.067$), and health promotion ($X^2 = 0.00$, $P=0.988$)

The findings also show that there is a significant relationship between respondents' sex and respondents' knowledge on selected ANC services as shown by the chi square values and the p-values of less than 0.05 with a degree of freedom of 1: immunization ($X^2 = 3.88$, $P=0.049$), Vaccination ($X^2 = 11.07$, $P=0.001$), early detection of complication and prompt of treatment ($X^2 = 28.87$, $P=0.000$) and counseling ($X^2 = 4.72$, $P=0.030$).

Table 4. 9: Education attainment and Knowledge on ANC services

ANC Services	Education Attainment					Chi-Square Tests		
	None	Primary	Secondary	Tertiary	Total	Pearson Chi-Square Value	Df	Sig. (2-sided)
Family planning	2.7	19.7	35.5	42.1	183	1.99	3	0.576
Immunization	3.0	16.3	28.9	51.9	135	19.93	3	0.000
Vaccination	2.8	15.9	30.3	51.0	145	21.85	3	0.000
Birth preparedness	2.9	22.7	35.5	39.0	172	5.91	3	0.116
Health promotion	2.4	17.7	35.5	44.4	124	1.99	3	0.575
Early det. of complication & prompt of treat.	3.5	19.3	31.6	45.6	114	3.10	3	0.376
Counseling	2.9	19.9	35.7	41.5	171	1.23	3	0.746

Table 9 shows the frequency and percent distribution of respondents' education attainment and their knowledge on ANC services. The findings show that respondents with no education were the lowest (2.7 percent) in knowledge on family planning. This was followed by those that had attained primary and secondary levels presenting 19.7 and 35.5 percent respectively. The respondents that had attained tertiary level were the highest 42.1 percent in knowing about family planning.

Additionally, the findings show that, there is no significant relationship between education attainment and respondents' knowledge on selected ANC services as shown by the chi square values and the p-values of greater than 0.05: family planning ($\chi^2 = 1.99$, $P=0.576$), birth preparedness ($\chi^2 = 5.91$, $P=0.116$), health promotion ($\chi^2 = 1.99$, $P=0.575$), early detection of complications and prompt treatment ($\chi^2 = 3.10$, $P=0.376$) and counseling ($\chi^2 = 1.23$, $P=0.746$)

Furthermore, the findings show that there is a significant relationship between education attainment and respondents' knowledge on immunization and vaccination, as shown by the chi square values of 19.93 and 21.85 the p-values less than 0.05 (0.000) for each respectively.

Table 4. 10: Residence and Source of ANC services

Source of ANC Services	Residential			Chi-Square Tests			
	Rural	Urban	Total	Pearson Square Value	Chi- Df	Sig. (2-sided)	
Know ANC services through Media	51.9	48.1	158	0.16	1	0.692	
Know ANC services through friends	41.4	58.6	116	14.51	1	0.000	
Know ANC services through bill boards	16.3	83.7	49	34.55	1	0.000	
Know ANC services through posters	25.0	75.0	64	29.13	1	0.000	
Know ANC services through flyers	30.4	69.6	46	11.86	1	0.001	
Know ANC services through health workers	56.7	43.3	171	9.95	1	0.002	
Know ANC services through church members	53.8	46.2	78	0.27	1	0.602	

The table shows the frequency and percent distribution of respondents' residential areas and their source of knowledge on ANC services. The findings show that respondents from rural areas were more knowledgeable on ANC services through media as source of information presenting 51.9 percent as compared to respondents from urban areas with 48.1 percent. Analysis shows that there were more respondents from urban areas who acquired knowledge on ANC services through friends, bill boards, posters and flyers with the following percentages; 58.6, 83.7, 75.0 and 69.6 respectively. While respondents from rural areas had little knowledge on ANC services

through following sources; friends, bill boards, posters and flyers with the following percentages; 41.4, 16.3, 25.0 and 30.4 respectively. The findings further show high levels of knowledge in ANC services acquired in rural areas through health workers with 56.7 percent and church members with 53.8, as sources of information while respondents in urban areas had little knowledge in ANC services acquired through health workers with 43.3 and through church members with 46.2 percent as sources of getting information on ANC services.

Additionally, the findings show that, there is no significant relationship between respondents' residences and respondents' knowledge on ANC services on sources of information as shown by the chi square values and the p-values of greater than 0.05: media(Radio, Newspapers, TV) ($\chi^2 = 0.16$, $P = 0.692$) and church members ($\chi^2 = 0.27$, $P = 0.602$) respectively.

Further, the findings show that, there is a significant relationship between respondents' residences and respondents' knowledge on selected sources of information on ANC services as shown by the chi square values and p-values less than 0.05: friends ($\chi^2 = 14.51$, $p = 0.000$), bill boards ($\chi^2 = 34.55$, $P = 0.000$), posters ($\chi^2 = 29.13$, $P = 0.000$), flyers ($\chi^2 = 11.86$, $P = 0.001$), and lastly health workers ($\chi^2 = 9.95$, $P = 0.002$).

Table 4. 11: Marital Status and Knowledge on ANC services

Knowledge on ANC Services	Marital Status				Chi-Square Tests		
	Single	Married	Divorced	Total	Pearson Chi-Square Value	Df	Sig. (2-sided)
Know family planning	5.5	92.9	1.6	183	8.00	2	0.018
Know immunization	7.4	91.1	1.5	135	0.36	2	0.834
Know vaccination	7.6	90.3	2.1	145	1.81	2	0.405
Know birth preparedness	6.4	91.9	1.7	172	0.64	2	0.725
Know health promotion	6.5	91.9	1.6	124	0.04	2	0.979
Know early detection of complication and prompt of treatment	8.8	88.6	2.6	114	4.17	2	0.124
Know counseling	7.6	90.6	1.8	171	2.35	2	0.310

The table shows the frequency and percent distribution of respondents' marital status and their knowledge on selected ANC services. The findings show that respondents who were divorced were the lowest, followed by the single parents and highest were married spouses in knowledge on all selected ANC services. Respondents' knowledge on family planning; divorced (1.6 percent), single (5.5 percent) and married (92.9 percent). Respondents' knowledge on immunization; divorced (1.5 percent), single (7.4 percent) and married (91.1 percent). Respondents' knowledge on vaccination; divorced (2.1 percent), single (7.6 percent) and married (90.3 percent). Respondents' knowledge on birth preparedness; divorced (1.7 percent), single (6.4 percent) and married (91.9 percent). Respondents' knowledge on health promotion; divorced (1.6 percent), single (6.5 percent) and married (91.9 percent). Respondents' knowledge on early detection of complications and prompt of treatment; divorced (2.6 percent), single (8.8 percent) and married (88.6 percent). Lastly, the respondents' knowledge on counseling; divorced (1.8 percent), single (7.6 percent) and married (90.6 percent).

Additionally, the analysis done between marital status and respondents' knowledge on family planning is significant as shown by the chi square values of 8.00 and the p-values less than 0.05 (0.018). Further, the analysis done show that, there is no significant relationship between marital status and respondents' knowledge on selected ANC services as shown by the chi square values and p-values of greater than 0.05; immunization ($\chi^2 = 0.36$, $p=0.834$), vaccination ($\chi^2 = 1.81$, $P=0.405$), birth preparedness ($\chi^2 = 0.64$, $P=0.725$), health promotion ($\chi^2 = 0.04$, $P=0.979$), early detection of complications and prompt treatment ($\chi^2 = 4.17$, $P=0.124$), and counseling ($\chi^2 = 2.35$, $P=0.310$).

Table 4.12: Residence and Source of PNC services

Source of PNC Services	Residential			Chi-Square Tests			
	Rural	Urban	Total	Pearson Chi-Square Value	Df	Sig. (2-sided)	
Know PNC services through Media	55.6	44.4	187	3.57	1	0.059	
Know PNC services through friends	49.6	50.4	125	1.73	1	0.188	
Know PNC services through bill boards	13.5	86.5	52	44.15	1	0.000	
Know PNC services through posters	27.1	72.9	70	28.94	1	0.000	
Know PNC services through flyers	28.3	71.7	46	14.88	1	0.000	
Know PNC services through health workers	56.0	44.0	184	4.18	1	0.041	
Know PNC services through church members	49.5	50.5	99	1.11	1	0.292	

The table shows the frequency and percent distribution of respondents' residential areas and their source of knowledge on PNC services. The findings show that respondents from rural areas were more knowledgeable on PNC services through media and health workers as source of information presenting 55.6% and 56.0% as compared to respondents from urban areas with 44.4% and 44.0% respectively. Analysis shows that there were more respondents from urban areas who acquired knowledge on ANC services through friends, bill boards, posters, flyers and church members as indicated on the table. While respondents from rural areas had little knowledge on ANC services through following sources; friends, bill boards, posters and flyers as indicated on the table above.

Additionally, the findings show that there is no significant relationship between respondents' residences and respondents' knowledge on PNC services on sources of information as shown by the chi square values and the p-values of greater than 0.05: media(Radio, Newspapers, TV) ($X^2 = 3.57$, $P=0.059$), friends ($X^2 = 1.73$, $P=0.188$) and church members($X^2 = 1.11$, $P=0.292$) respectively.

The findings further show significant relationship between residence and respondents' knowledge on PNC services as shown by the chi square values and the p-values of less than 0.05:

Bill boards ($X^2 = 44.15$, $P=0.000$), Posters ($X^2 = 28.94$, $P=0.000$) and Flyers ($X^2 = 4.18$, $P=0.041$) respectively.

Table 4.13: Residence and Type of ANC services Used

ANC Service Used	Residential			Chi-Square Tests		
	Rural	Urban	Total	Pearson Chi-Square Value	Df	Sig. (2-sided)
Used family planning	45.3	54.7	106	5.57	1	0.018
Used immunization	55.2	44.8	87	0.20	1	0.653
Used Vaccination	52.3	47.7	128	0.13	1	0.719
Used birth preparedness	57.6	42.4	172	6.82	1	0.009
Used health promotion	52.5	47.5	101	0.06	1	0.810
Used early detection of complication and prompt of treatment	55.1	44.9	118	0.33	1	0.565
Used counseling	53.7	46.3	147	0.03	1	0.856
Used disease presentational treatment among pregnant women	60.9	39.1	110	7.81	2	0.020

The table shows the frequency and percent distribution of respondents' residence and the use of ANC services. The findings show that respondents from rural areas were more adherences to the uptake of ANC services presenting: Immunization 55.2%, vaccination 52.3%, birth preparedness 57.6 %, health promotion 52.5 %, early detection of complications and prompt of treatment 55.1% and lastly counseling 53.7 %. This was followed by the respondents from urban areas presenting: family planning with 54.7 % and disease presentational treatment among pregnant women with 60.9 %.

In addition, the findings show that there is no significant relationship between respondents' residences and the type of ANC services used as shown by the chi square values and the p-values of greater than 0.05: immunization ($X^2 = 0.20$, $P=0.653$), vaccination ($X^2 = 0.13$, $P=0.719$), health promotion ($X^2 = 0.06$, $P=0.810$), early detection of complications and prompt treatment ($X^2 = 0.33$, $P=0.565$) and counseling ($X^2 = 0.03$, $P=0.856$).

Furthermore, the findings show that there is a significant relationship between respondents' residences and the type of ANC services used such as family planning, birth preparedness and

disease presentational treatment among pregnant women as shown by the chi square values of 5.57, 6.82 and 7.81 with the p-values less than 0.05 (0.018, 0.009 and 0.020) for each respectively.

Table 4. 14: Sex and Type of ANC services used

ANC Service Used	Sex		Chi-Square Tests		
	Male	Female	Pearson Chi-Square Value	Df	Sig. (2-sided)
Used family planning	45.1	58.0	3.39	1	0.066
Used immunization	32.0	54.5	10.74	1	0.001
Used Vaccination	52.5	72.7	8.82	1	0.003
Used birth preparedness	86.1	76.1	3.40	1	0.065
Used health promotion	43.4	54.5	2.52	1	0.112
Used early detection of complication and prompt of treatment	46.7	69.3	10.60	1	0.001
Used counseling	62.3	80.7	8.23	1	0.004
Used disease presentational treatment among pregnant women	41.0	68.2	15.82	2	0.000
Total	122	88			

The table shows the frequency and percent distribution of respondents' sex and the type of ANC services used. The findings show that female respondents were more adherent to the uptake of ANC services in all but one presenting: family planning 58.0 %, Immunization 54.5 %, vaccination 72.7 %, health promotion 54.5 %, early detection of complications and prompt of treatment 69.3 %, presentational treatment among pregnant women 6.2 % and lastly counseling 80.7 %. This was followed by the respondents from rural areas presenting birth preparedness with 86.1% only.

The findings show that there is no significant relationship between respondents' sex and the type of ANC services used by respondents as shown by the chi square values and the p-values of greater than 0.05: family planning ($X^2 = 3.39$, $P = 0.066$), birth preparedness ($X^2 = 3.40$, $P = 0.065$), and health promotion ($X^2 = 2.52$, $P = 0.112$).

Further, it has been revealed that there is a significant relationship between respondents' sex and the type of ANC services used by respondents such as immunization, vaccination, early detection of complications and prompt of treatment, counseling and disease presentational treatment among pregnant women as shown by the chi square with the p-value of less than 0.05 for each respectively as shown on the table above.

Table 4.15: Marital status and Type of ANC services used

ANC Services Used	Marital Status				Chi-Square Tests		
	Single	Married	Divorced	Total	Pearson Chi-Square Value	Df	Sig. (2-sided)
Used family planning	6.6	91.5	1.9	106	0.32	2	0.852
Used immunization	10.3	89.7	0.0	87	5.22	2	0.074
Used Vaccination	7.8	90.6	1.6	128	0.75	2	0.689
Used birth preparedness	4.7	93.6	1.7	172	6.75	2	0.034
Used health promotion	5.9	92.1	2.0	101	0.57	2	0.752
Used early detection of complication and prompt of treatment	8.5	89.8	1.7	118	1.58	2	0.454
Used counseling	8.2	89.8	2.0	147	3.17	2	0.205
Used disease presentational treatment among pregnant women	9.1	88.2	2.7	110	5.16	4	0.271

The table shows the frequency and percent distribution of respondents' marital status and the respondents' adherence and uptake of selected ANC services. As expected the findings show that married respondents had highest response in the uptake of all selected ANC services as highlighted above.

The analysis done between marital status and respondents' uptake and adherence on family planning show significant value as shown by the chi square values of 6.75 and the p-values less than 0.05(0.034).

Further, the analysis done show that, there is no significant relationship between marital status and respondents' uptake and adherence on selected ANC services as shown by the chi square values and p-values of greater than 0.05;family planning $\chi^2 = 0.32$, $p = 0.852$ immunization (χ^2

=5.22, $p=0.074$), vaccination ($X^2 =0.75$, $P=0.689$), disease presentational among pregnant women($X^2 =5.16$, $P=0.271$), health promotion ($X^2 =0.57$, $P=0.752$), early detection of complications and prompt treatment ($X^2 =1.58$, $P=0.454$), and counseling ($X^2 =3.17$, $P=0.205$) respectively.

Table 4.16: Education attainment and Type of ANC services used

ANC Services Used	Education Attainment					Chi-Square Tests		
	None	Primary	Secondary	Tertiary	Total	Pearson Chi-Square Value	Df	Sig. (2-sided)
Used family planning	4.7	18.9	33.0	43.4	106	3.13	3	0.372
Used immunization	5.7	21.8	29.9	42.5	87	3.69	3	0.297
Used Vaccination	3.9	21.1	30.5	44.5	128	3.64	3	0.303
Used birth Preparedness	4.1	25.0	33.7	37.2	172	6.40	3	0.094
Used health Promotion	2.0	24.8	27.7	45.5	101	5.50	3	0.139
Used early detection of complication and prompt of treatment	5.1	22.9	30.5	41.5	118	3.79	3	0.285
Used counseling	4.1	21.8	31.3	42.9	147	3.19	3	0.4
Used disease presentational treatment among pregnant women	5.5	25.5	29.1	40.0	110	7.67	6	0.263

The table shows the frequency and percent distribution of respondents' education attainment and their uptake and adherence on ANC services. The findings show that respondents with no education were the lowest, followed by primary and then secondary and finally tertiary education. Respondents' education attainment and uptake of family planning: none (4.7 %), primary education (18.9 %), secondary (33 %) and tertiary education (43.4 %). Respondents' education attainment and uptake of immunization: none (5.7%), primary (21.8 %), secondary (29.9 %) and tertiary (42.5 %). Respondents' education attainment with vaccination: none (3.9 %), primary (21.1%), secondary (30.5 %) and tertiary (42.5%).

Additionally, the findings show that, there is no significant relationship between education attainment and respondents' uptake and adherence in all selected ANC services as shown by the

chi square values and the p-values of greater than 0.05 with a degree of freedom of 3 : family planning ($X^2 = 3.13$, $P=0.372$), immunization ($X^2 = 3.69$, $P=0.297$), vaccination ($X^2 = 3.64$, $P=0.324$). Therefore, the test shows that there is no significant relationship between respondent's education attainment and the uptake of ANC services.

Table 4. 17: Economic activities and Type of ANC services used

ANC Services Used	Economic Activity						Chi-Square Tests		
	Public sector	Self employed	Unemployed	Home duties	Retired	Total	Pearson Chi-Square Value	Df	Sig. (2-sided)
Used family planning	45.3	34.9	0.9	17.9	0.9	106	11.78	4	0.019
Used immunization	41.4	28.7	0.0	28.7	1.1	87	17.43	4	0.002
Used Vaccination	37.5	32.0	0.0	24.2	6.3	128	12.95	4	0.012
Used birth preparedness	32.0	41.9	1.2	20.3	4.7	172	9.68	4	0.046
Used health promotion	40.6	27.7	1.0	22.8	7.9	101	12.25	4	0.016
Used early detection of complication and prompt of treatment	33.9	32.2	0.0	27.1	6.8	118	17.47	4	0.002
Used counseling	38.1	31.3	0.7	23.8	6.1	147	15.12	4	0.004
Used disease presentational treatment among pregnant women	32.7	29.1	0.0	31.8	6.4	110	32.05	8	0.000

The table shows the frequency and percent distribution of respondents' economic activities and their uptake on selected ANC services. The findings of this study show a high response from public sector followed by self-employed in ANC services used as compared to other sectors. The findings show that respondent' economic activities and uptake of family planning: public sector (45.3 %), self- employed (34.9 %), unemployed (0.9 %), home duties (17.9 %) and retired (0.9 %). Respondents' economic activities and uptake of immunization: public sector (41.4 %), self-employed (28.7 %), home duties (17.9 %) and retired (0.9 %). Respondents' economic activities and uptake of vaccination: public sector (37.5 %), self -employed (32.0 %), unemployed (0.0 %), home duties (24.2 %) and retired (6.3 %).

Further, the findings of the study show that there is significant relationship between economic activities and respondents' uptake and adherence on all selected ANC services as shown by the chi square values and the p-values of less than 0.05 with a degree of freedom of 4: family planning ($\chi^2 = 11.78$, $P=0.019$), immunization ($\chi^2 = 17.43$, $P=0.002$), birth preparedness ($\chi^2 = 9.68$, $P=0.046$), vaccination ($\chi^2 = 12.95$, $P=0.012$), health promotion ($\chi^2 = 12.25$, $P=0.016$).

4.6 Male Involvement in ANC services

During Focus Group Discussions lack of knowledge of the benefits and need of male involvement in maternal health services were reported to contribute to low male involvement in maternal health services. This is emphasized by some of the responses from focus group discussions;

“Most men in this area (village) are just reluctant to discuss or accompany their wives to the health centres for ANC and PNC services because they think it is not a big issue that may need their attention or participation”.

In the same focus group discussion, one participant had this to say.

“I have had seven children but I have always gone for ANC, delivery and PNC services without my husband. I wonder why these days you want women to be accompanied by their partners yet ANC, delivery and PNC services is intended for the pregnant women alone” (Maggie from Bubala village)..

Accompanying spouses for antenatal care services had many challenges more especially in rural areas as highlighted by one man during the focus group discussion, he had this complaint to share with the members.

“If I accompany my wife to the hospital every time she goes for her ANC checkups, my friends would think I am a weakling. They would laugh at me. Men who accompany their wives to health services are perceived to be weaklings by their peers “Bakazyondolwa” (Malumbe from Chiinya village).

While most respondents supported the view of male involvement in maternal health services, on the issue of the labour and delivery they were not sure of how and when to participate in

maternal health services. They supported male involvement in antenatal and postnatal just on first bookings only not on subsequent visits. In their views, men perceived accompanying a spouse for subsequent antenatal and postnatal care visits as a waste of time as there was no specific service for them. In the discussion, women reported that it was a shameful thing for a husband to witness a wife giving birth. They reiterated that male involvement, especially during labor was a foreign culture it has nothing to do with our African tradition, it is a taboo and it should not be tolerated. The health providers alluded to the strings of culture to have influence in male participation in health services in the study area. There were mixed responses during the FGD, when men were asked about witnessing the birth of their babies. Some older men were more likely than the younger men to feel that it was culturally disrespectful for a man to see a woman giving birth. However, there were exceptions in the discussions where few men were allowed into the labor ward but chose not to return either because they thought their wife would not like to be seen in that manner in labor, or they were afraid of what they would see in the labor ward. One respondent said that:

“When I entered the labour room I found some women beating walls with their hands due to pain and I felt afraid that aim also going to see my wife doing that. I went and stood outside I never went back.”

Increasingly, whilst acknowledging that it was not true, some participants frequently reported that traditionally, Lenje people (Chamuka area) believed that the presence of the husband at the time of delivery delays the birth of the baby.

Some men in the focus group discussion conducted in the Kabwe urban expressed willingness to participate in maternal health services, but were unable due to employment schedules that conflicted with clinic hours of operation.

4.7: Male involvement in ANC

With regard to the antenatal care services, the study found that 79.5 % of the respondents reported that they had been involved with their spouses in antenatal care services. Respondents from Kabwe rural were more likely to have been involved with their spouses (85.7 %) compared to the respondents from Kabwe urban (72.4 %).

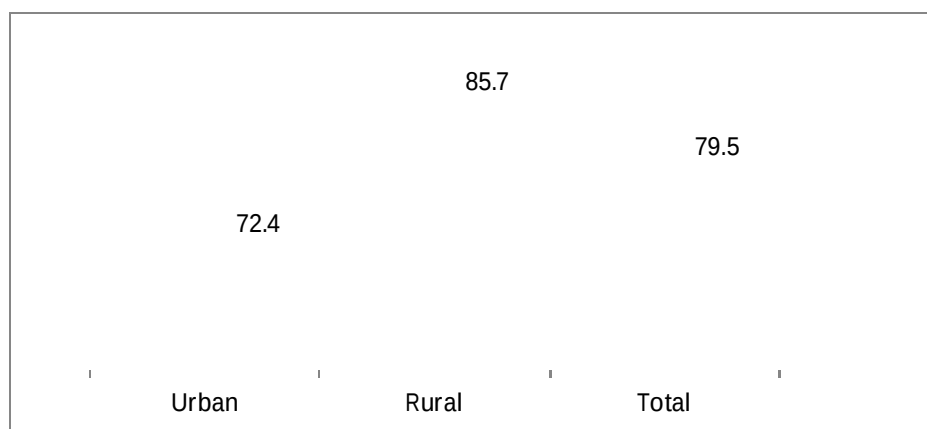


Figure 4.7: Male involvement in ANC

Source: Field Data, 2012.

It was further revealed that among the respondents who reported having ever been accompanied by their male spouse, 52.4% reported that they are rarely accompanied by their male spouse, 32.5% reported they are often accompanied by their male spouse and only 15.1% reported that they are very often accompanied by their male spouses.

Focus group suggested a number of reasons for men to play limited role during maternal health period one of them which came out eminently was the traditional practice of women going to their natal homes for delivery. Participants from Chiinya and Chilupula villages cited this as a reason for their lower involvement.

“Young women normally go for their delivery to their natal homes. This way the parents of a woman restrict the involvement of in-laws in the delivery care .Parents of the woman think it is disgraceful to involve in-laws in matters related to delivery care, thus husbands cannot be blamed for this act”.

The respondents in FGD expressed their challenge that they did not participate in physical examination of the women and other services unless the spouse had a medical complication that required the husband to be treated as well, such as HIV/AIDS or Sexual Transmitted Infections (STIs). In the same discussion of the pursuant of male involvement in maternal health services, one male participant had this experience to share.

“Even when we accompany our wives during labor we are not allowed into the delivery room and we are made to end our anxious journey at the waiting room just imagine!” (Maambo - Chiinya village).

During the face to face interviews with the health providers, it was evident from the discussions that health providers themselves were socialized to treat the health Centres as a place meant for women as one Clinical officer openly said.

“Even for us, health staff, if a person was accompanied by her partner to the clinic we would rather make the partner stand outside and let the woman go in alone, men are only called in the examination room when there is a complication”.

The other reason illuminated by health providers for turning male spouses away more especial in labour ward was lack of space for couples in the wards. One health staff had this to share.

“In Kabwe district, wards were often crowded and in reality not set up for couples. Labor ward is not only for one woman in the labor ward, sometimes there are more than ten (10). The clinics are congested in Kabwe. There is not enough space to accommodate the women and their husbands. Normally men will not feel comfortable sitting with women who are strangers to them in the screening room they will rather wait outside and if the procedures take long, they will leave” (MCH coordinator-Katondo clinic).

Table 4.18: Residence and Male involvement in ANC services

	Residential		
Has your spouse ever accompanied you for ANC services	Rural	Urban	Total
Yes	96	71	167
No	57.5	42.5	100
	16	27	43
	37.2	62.8	100
Total	112	98	210
	53.3	46.7	100
Chi-Square Tests			
Pearson Chi-Square Value	Df	Sig. (2-sided)	
5.65	1	0.017	

****Note that the highlighted figures are percentages***

The table shows the frequency and percent distribution of respondents' residential areas and their accompanying of spouses for antenatal care services. The findings show that rural areas respondents were the majority (57.5 %) while urban respondents were 42.5 %. Respondents who were not accompanying spouses, urban areas were majority (62.8 %) while rural areas respondents were 37.2 % only.

The findings show that there is a significant relationship between respondents' residence and accompanying spouse for ANC services as shown by the chi square value and the p-value of less than 0.05 with a degree of freedom of 2 ($\chi^2 = 5.65$, $P = 0.017$).

This finding asserts that people in the urban areas despite being knowledgeable in issues pertaining to maternal health services the uptake of these health services is poor. On the other hand people in the rural areas despite having insufficient knowledge in maternal health services coupled with numerous challenges in accessing health services, there is massive commitment in accompanying spouses for maternal health services.

Table 4.19: Marital status and Male involvement in ANC services

Has your spouse ever accompanied you for ANC services * Marital Status Crosstabulation						
Has your spouse ever accompanied you for ANC services			Marital Status			
			Single	Married	Divorced	Total
Yes			9	157	1	167
94%			5.4	94.0	0.6	100
No			5	36	2	43
83.7%			11.6	83.7	4.7	100
Total			14	193	3	210
			6.7	91.9	1.4	100
Chi-Square Tests						
Pearson Chi-Square Value		Df	Sig. (2-sided)			
6.32		2	0.042			

****Note that the highlighted figures are percentages***

The table shows the frequency and percent distribution of respondents' marital status and their accompanying of spouses for ANC services. As expected in this study the percentage of married couples (the only inclusion criteria) who ever accompanied their spouses was 94.0 %.

The finding show that there is a significant relationship between respondents' marital status and accompanying spouse for ANC services as shown by the chi square value and the p-value of less than 0.05 with the degree of freedom of 2 ($X^2 = 6.32$, $P = 0.042$).

Table 4.20: Marital status and Male involvement in PNC services

PNC Services Men are Involved In	Marital Status			Chi-Square Tests			
	Single	Married	Divorced	Total	Pearson Chi-Square Value	df	Sig. (2-sided)
Men mostly involved in family planning	4.6	94.5	0.9	109	2.38	4	0.667
Men mostly involved in counseling	7.8	90.4	1.8	167	2.52	4	0.642
Men mostly involved in health promotion	6.3	93.8	0.0	80	2.17	4	0.705
Men mostly involved in birth preparedness	3.8	94.3	1.9	53	1.26	4	0.868
Men mostly involved in disease prevention	8.5	91.5	0.0	71	2.23	4	0.694
Men mostly involved in immunization	11.5	86.5	1.9	52	2.90	4	0.574
Men mostly involved in VCT testing	7.7	90.5	1.8	168	2.40	4	0.662

The table shows the frequency and percent distribution of respondents' marital status and PNC services where men were mostly involved. As expected, the findings show that respondents who were married were the highest, followed by the single parents in male involvement in selected PNC services. Respondents' marital status and levels of male involvement in family planning; divorced (0.5 percent), single (4.6%) and married (94.5 %). Respondents' counseling; divorced (1.8 %), single (7.8 %) and married (90.4 %). Lastly, respondents' marital status and levels of male involvement in immunization divorced (1.9 %), single (11.5 %) and married (86.5 %).

The analysis done between respondents' marital status and selected PNC services where men were mostly involved is insignificant as shown by the chi square values and the p-values of

greater than 0.05 with the degree of freedom of 4: family planning($X^2 = 2.38$, $p=0.667$), counseling ($X^2 = 2.52$, $p=0.642$), immunization ($X^2 = 2.90$, $P=0.574$), and VCT testing ($X^2 = 2.40$, $P=0.662$) respectively.

4.8 Male involvement in PNC services.

With regard to the postnatal care services, the study found that 76 % of the respondents reported that they had been accompanied by their male spouses for postnatal care services. Respondents from Kabwe rural were more likely to have been accompanied by their male spouses (90.2 %) compared to the respondents from Kabwe urban (66.3 %).

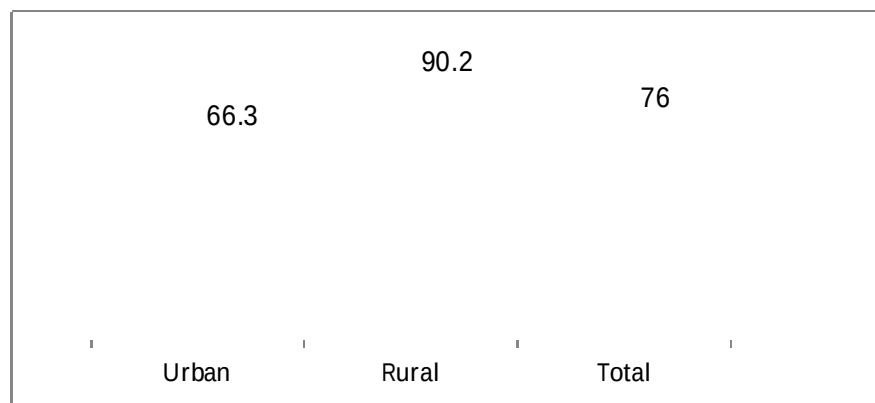


Figure 4.8: Male involvement in PNC services. Source: Field Data, 2012.

Table 4.21: Economic Activities and Male involvement in PNC services

PNC Services Men are Involved in	Economic Activity						Chi-Square Tests		
	Public sector	Self employed	Unemployed	Home duties	Retired	Total	Pearson Chi-Square Value	Df	Sig. (2-sided)
Men mostly involved in family planning	44.0	36.7	0.0	16.5	2.8	109	12.91	8	0.115
Men mostly involved in counseling	32.9	39.5	1.2	21.0	5.4	167	8.24	8	0.410
Men mostly involved in health promotion	40.0	47.5	1.3	7.5	3.8	80	16.32	8	0.038
Men mostly involved in birth preparedness	62.3	28.3	1.9	1.9	5.7	53	30.88	8	0.000
Men mostly involved in disease prevention	40.8	33.8	0.0	14.1	11.3	71	16.89	8	0.031
Men mostly involved in immunization	57.7	32.7	0.0	5.8	3.8	52	20.44	8	0.009
Men mostly involved in VCT testing	33.3	39.3	0.6	21.4	5.4	168	9.28	8	0.319

The table shows the frequency and percent distribution of respondents' economic activities and male involvement in PNC services. The findings show the respondents' economic activities and male involvement in selected PNC services. Respondents' economic activities and male involvement in family planning; public sector (44.0 %), self- employed (36.7 %), unemployed (0.0 %), home duties (16.5 %) and retired (2.8 %). Respondents' economic activities and male involvement in immunization: public sector (57.7 %), self- employed (32.7 percent), unemployed there was none, home duties (5.8 percent) and retired (3.8 percent).lastly respondents' economic activities and male involvement in VCT testing: public sector (33.3 %), self- employed (39.3 %), unemployed (0.6 %), home duties (21.4 %) and retired (5.4%).

The analysis done between respondents' economic activities and male involvement in selected PNC services is insignificant as shown by the chi square values and the p-values of greater than 0.05 with the degree of freedom of 4: family planning($\chi^2 = 12.91$, $p = 0.115$), counseling ($\chi^2 = 8.24$, $p = 0.410$) and VCT testing ($\chi^2 = 9.24$, $P = 0.319$) respectively.

Further analysis done between respondents' economic activities and male involvement in health promotion, birth preparedness, disease prevention and immunization is significant as shown by the chi square values and the p values of less than 0.05 with a degree of freedom of 4: health promotion ($\chi^2 = 16.32$, $P=0.038$), birth preparedness ($\chi^2 = 30.88$, $P=0.000$), disease prevention ($\chi^2 = 16.89$, $P=0.031$) and immunization ($\chi^2 = 20.44$, $P=0.009$) respectively.

Table 4. 22: Education Attainment and Male involvement in PNC services

PNC Services Men are Involved in	Education Attainment					Chi-Square Tests		
	None	Primary	Secondary	Tertiary	Total	Pearson Chi-Square Value	df	Sig. (2-sided)
Men mostly Involved in family Planning	3.7	20.2	31.2	45.0	109	6.22	6	0.399
Men mostly Involved in counseling	4.2	24.0	35.9	35.9	167	8.47	6	0.205
Men mostly Involved in health Promotion	1.3	28.8	33.8	36.3	80	7.33	6	0.291
Men mostly Involved in birth Preparedness	0.0	15.1	22.6	62.3	53	19.48	6	0.003
Men mostly involved in disease prevention	4.2	23.9	23.9	47.9	71	8.87	6	0.181
Men mostly involved in Immunization	0.0	23.1	19.2	57.7	52	15.96	6	0.014
Men mostly involved in Vct testing	4.2	23.8	33.3	38.7	168	5.82	6	0.443

The table shows the frequency and percent distribution of respondents' education attainment and male involvement in selected PNC services. The findings show that respondents with tertiary education were the highest, followed by secondary and then primary and finally respondents with no education. The findings of this study present that men with tertiary educational attainment are involved in birth preparedness (62.3 %), immunization (57.7 %) and family planning (45.0 %).

The findings show that there is no significant relationship between education attainment and male involvement in selected PNC services as shown by the chi square values and the p-values of greater than 0.05 with a degree of freedom of 6 : family planning ($\chi^2 = 6.22$, $P=0.399$), counseling ($\chi^2 = 8.47$, $P=0.205$), health promotion ($\chi^2 = 7.33$, $P=0.291$), disease prevention ($\chi^2 = 8.87$, $P=0.181$) and VCT testing ($\chi^2 = 5.82$, $P=0.443$).

Further, the findings of the study show that there is significant relationship between education attainment and male involvement in birth preparedness and immunization as shown by the chi square values and the p-values of less than 0.05: birth preparedness ($X^2 = 19.48$, $P=0.003$) and immunization ($X^2 = 15.96$, $P=0.014$).

Table 4. 23: Residence and Male involvement in PNC services

PNC Services Men are Involved in	Residential		Total	Chi-Square Tests		
	Rural	Urban		Pearson Chi-Square Value	Df	Sig. (2-sided)
Men mostly involved in family planning	45.0	55.0	109	9.58	2	0.008
Men mostly involved in Counseling	58.7	41.3	167	10.27	2	0.006
Men mostly involved in health promotion	57.5	42.5	80	3.01	2	0.223
Men mostly involved in birth preparedness	32.1	67.9	53	15.85	2	0.000
Men mostly involved in disease prevention	57.7	42.3	71	2.97	2	0.227
Men mostly involved in Immunization	40.4	59.6	52	7.36	2	0.025
Men mostly involved in VCT testing	60.1	39.9	168	16.12	2	0.000

Source: Field Data 2012.

The table shows the frequency and percent distribution of respondents' residence and male involvement in selected PNC services. The findings show that respondents in the urban areas were the majority (55.0 %) in knowledge on family planning, while those in rural areas were 45.0 %. Male involvement in counseling, respondents from the rural areas was the majority (58.7 percent while those from urban were 41.3 percent. Male involvement in birth preparedness most of the respondents were from urban areas (67.9 %) while those from rural areas were 32.1 %. Male involvement in immunization the majority of the respondents were from urban areas (59.6 %) while those from rural areas were 40.4 % only. Male involvements in VCT testing were high among the respondents from rural areas (60.1%) while those from urban areas were 39.9 % only.

The findings show that there is no significant relationship between residence and level of male involvement in PNC services in health promotion and disease prevention as shown by the chi square values and the p-values of greater than 0.05: health promotion ($X^2 = 3.01$, $P = 0.223$), and disease prevention ($X^2 = 2.97$, $P = 0.227$)

Further, the findings show the significance relationship between residence and male involvements in selected PNC services as shown by the chi square values and the p-values of less than 0.05: family planning ($X^2 = 9.58$, $P = 0.008$), counseling ($X^2 = 10.27$, $P = 0.006$), birth preparedness ($X^2 = 15.85$, $P = 0.000$), immunization ($X^2 = 7.36$, $P = 0.025$) and lastly, VCT testing ($X^2 = 16.12$, $P = 0.006$).

Table 4. 24: Sex and Perception towards PNC services

PNC services should only be left to women alone	Sex	
	Male	Female
strongly agree	13	14
	10.7	15.9
Agree	5	5
	4.1	5.7
Uncertain	6	0
	4.9	0.0
Strongly disagree	34	40
	27.9	45.5
Disagree	64	29
	52.5	33.0
Total	122	88
	100	100
Chi-Square Tests		
14.573	4	0.006

The table shows the frequency and percent distribution of respondents' sex and to whether PNC services should only be left to women alone. The findings show that female respondents who strongly agree to ascertain that PNC should only be left to women alone were 15.9 % while men were 10.7 %. Female respondents who agree to ascertain that PNC services should only be left to women alone were 5.7 %. Female respondents who strongly agree to ascertain that PNC services should only be left to women alone were 45.5 % while male spouses were 27.9 %. The male

respondents who totally disagree to ascertain that PNC services should only be left to women alone were 52.5 % while female respondents were 33.0 % only.

These findings show that there is a strong significant relationship between respondents' sex and to ascertain that PNC services should only be left to women alone as shown by the Chi square values and the p-values less than 0.05 with a degree of freedom of 4 ($\chi^2 = 14.573$, $P = 0.006$).

Table 4.25: Sex and Perception towards ANC services

	Sex	
Introduce paternity leave for male spouse to enable them care for their wives	Male	Female
strongly agree	21	27
	17.2	30.7
Agree	25	12
	20.5	13.6
Uncertain	21	0
	17.2	0.0
Strongly disagree	18	33
	14.8	37.5
Disagree	37	16
	30.3	18.2
Total	122	88
	100	100
Chi-Square Tests		
35.25	5	0.00

***Note that the highlighted figures are percentages**

The table shows the frequency and percent distribution of respondents' sex and the introduction of paternity leave for male spouses to enable them care for their wives. The findings show that not all the respondents in the study supported the introduction of paternity leave. However, some men and women are not in support of the introduction of paternity leave. About 45.1 percent of men do not support the introduction of paternity leave and 55.7 percent of women are not in support of the introduction of paternity leave.

Further, the findings show that, there is a strong significant relationship between respondents' sex and the introduction of paternity leave for male spouses to enable them care for their wives after they have given birth as shown by the chi square values and the p-values of less than 0.05 with a degree of freedom of 5 ($\chi^2 = 35.25$, $P = 0.000$).

Table 4.26: Sex and Perception on male involvement in ANC services

	Sex	
	Male	Female
Male spouses should be allowed in labour wards		
strongly agree	10	20
	8.2	22.7
Agree	9	15
	7.4	17.0
Uncertain	33	6
	27.0	6.8
Strongly disagree	30	27
	24.6	30.7
Disagree	40	20
	32.8	22.7
Total	122	88
	100	100
Chi-Square Tests		
Pearson Chi-Square Value	Df	Sig. (2-sided)
27.403	5	0.000

***Note that the highlighted figures are percentages**

The table shows the frequency and percent distribution of respondents' sex and to ascertain that male spouses should be allowed in labor wards during delivering. The findings show that not all the respondents in the study agree to ascertain that male spouses should be allowed in the labour wards. About 57.4 % of men do not support the idea and 53.4 % of women do not support the idea of allowing men in the labour wards during delivery.

Undeniably, the findings of this study show that there is a strong significant relationship between respondents' sex and the presence of male spouses in labour wards during delivery as shown by the chi square values and the p-values of less than 0.05 with a degree of freedom of 5 ($\chi^2 = 27.403$, $P=0.000$).

4.9 Strategies to improve male involvement

When respondents were asked to state what they think would help in improving male involvement in ANC and PNC services, the majority of the respondents felt that health centres should be located closer if male involvement was to be improved (80.7%). Respondents also felt that there is need to improve Information Education and Communication (IEC) system (71.1%),

increased sensitization by Community Health care workers (65.8%), Community leaders must be involved in information dissemination to encourage men to get involved (53.5%).

During the focus group discussion it was highlighted that there is lack of just cause in this crusade of male involvement in health matters. Most of the participants complained that there were no proper guidelines as to how men should participate in health issues during maternal health. Thus, the health providers were not sure as to what role the husbands would do in the maternal health care especially in the labour ward. The health providers also admitted when contacted that there was need for a written guidelines for male involvement in maternal health care and proper orientation to both health providers and the public populace. From the discussions, it seems that there was no actual activity that men can participate in after the first antenatal visits. One health officer made a comment concerning the same:

“Men are only called in the examination room when there is a complication to his spouse. Health providers should be given refresher courses because they seem to be losing direction.”

One of the strategies suggested in the discussions was that health providers are supposed to be targeting socializing agents such as communities, schools and mass media to disseminate the information on male involvements which could have an impact on behavior change of male spouses in the long run.

4.10 Factors affecting Male involvement in ANC services

However, the study obtained information on the factors affecting male involvement in ANC and PNC services by asking respondents what they think were the factors hindering male involvement in ANC and PNC services.

During the focus group discussion, shortage of drugs and supplies in the health centres was illuminated as a barrier in male involvement in health matters. Stock out of drugs and issuing of medical prescriptions to buy drugs from chemists and private owned clinics was cited as one of the reasons for the men not to accompany wives during the clinic days. It seems men are not comfortable with this idea of sending them to source drugs. One respondent said:

Health workers burden us a lot, when you accompany the spouse to the health center, they ask to buy almost everything required from private chemists. Most of these private chemists are owned by them (health providers), yet sometimes we don't have the money. That is why I have stopped accompanying my wife to avoid embarrassment."

In the same discussion, it was highlighted that long waiting time at the health centers coupled with concurrent job demand were the other factors mentioned in FGD as contributing to low male involvement in maternal health services. One participant had this comment to make:

"Sometimes the woman goes to the health centre for a clinical visit and she ends up spending up the whole day at the center. Now suppose I had gone with her who can look after the children back home? That is why I cannot attend ANC or accompany her for PNC services" (Mainza from Bubala village).

Distance to the health centers was also noted as a problematic in the study area. Walking was the means of transport in the study area. The distance to the health centers compounded with lack of financial resources was perceived as one of the challenges for male involvement in maternal health services Kabwe rural area. Walking to health centres takes 3-4 hours. Several of the men in the focus group discussion reported that due to socio-economic difficulties, they did not have time to attend ANC and PNC with their partners as demonstrated by the following narrations:

"I am busy trying to make the ends meet. I don't have time to go with her to the antenatal clinics. I don't have money for transport for two people. We have to struggle to look for money to provide for our families" (Malambo from Chiinya village).

In the key informants' interviews, age difference among participants came out eminently to pose challenges in male involvement in maternal health services. One of the health providers had this to tell on age difference among the clients.

There is a tendency amongst these grown up female spouses, you sometimes find that there are very few of them in the waiting room, when they are seated with

these young women they feel awkward, so you find that they become shy to bring their partners who are also old like her they are very few of them. Mostly it is these young ones who have high cases of falling pregnant”

In the same discussion, it was illuminated that open clinic infrastructure coupled with the lack of privacy posed a challenge to male involvement in maternal health services in Kabwe district. One health provider had this observation to say:

“It is not easy for men to come to health centres, though we are urging them to do so and they have got more than one partner so they are afraid to be seen at the clinic with this one. Somebody will see him and then go and blow the whistle to the other partner that his other partner is pregnant, so they fear that kind of embarrassment. Men with multiple partners may not want to be seen with a partner at the clinic they fear to be confronted by other potential partners”.

In the men’s discussion groups it was remarkably expressed that sometimes husbands do not actively participate in maternal health care because of shame. Sometimes men it is a shameful thing to go to the hospital with their wives because sometimes people would laugh at the men who accompany their wives to the clinic. So many men have a mentality that antenatal and postnatal care is only for women.

Communication between spouses, if it is not properly handled can be a barrier in male involvement in maternal health services. In a focus group discussion it was revealed that some women are themselves the main barriers to their husband participation effectively because women fail to communicate to their husbands about male involvement in health issues. The women who had picked a quarrel or do not want their husbands to participate would not communicate to them about male involvement. When women are asked by health providers, to come with their husbands during the subsequent clinical visits of them some do not relay the message to their husbands. It was up to individual women to choose whether to invite the husband or not. However, they were quick to say that husbands’ participation was solely depended upon the relationship which exists among couples. One woman had this to say:

“Every woman knows her husband. If the relationship with the husband is not good, then it is difficult to tell him to accompany you to the health centre” (Judy from Chiinya village).

Poor inter spouse communication and men’s negative attitude is also a challenge in involving men in maternal health services. This emerged from the FGDs in Chamuka area. One respondent had the following to say:

“Women do not discuss much about health issues with men. They generally discuss it with their female friends and relatives. They only involve men when there is a problem or complication. So when these women have taken the responsibility on themselves, why should we bother?”(Munsanje from Chilupula village).

Table 4.27: Sex and Factors affecting male involvement in ANC services

	Sex		Chi-Square Tests		
	Male	Female	Pearson Chi-Square Value	df	Sig. (2-sided)
Shyness	62.5	58.0	0.44	1	0.507
Stigma	53.3	53.4	0.00	1	0.985
Traditional beliefs	53.3	75.0	10.28	1	0.001
Distance to ANC centres	63.1	40.9	10.14	1	0.001
Programme is for women	19.7	27.3	1.67	1	0.196
lack of finances	36.7	12.5	15.24	1	0.000
Total	120	88			

The table shows the frequency and percent distribution of respondents’ sex and factors affecting male involvement in ANC services. The findings show that female respondents who reported shyness as a factor in male involvement in ANC/PNC services were 58.0 % while male respondent were 62.5 %. The female respondents who reported stigma as a factor affecting male involvement in ANC/PNC services were 53.4 % slightly higher than that of male respondents (53.3%). The male respondents who reported traditional beliefs as a factor affecting male involvement in ANC/PNC services were 53.3 % lower than that of female respondents (75.0 %). The findings also show that men who reported long distance to health centers has more effect on male respondents were 63.1 % higher than that of female respondents (40.9 %).

Surprisingly, the findings show that there is no significant relationship between respondents' sex and some factors affecting male involvement in ANC services as shown by the Chi square values and the p-values of more than 0.05 with 1 degree of freedom: shyness($\chi^2 = 0.44$, $P=0.507$), stigma($\chi^2 = 0.00$, $P=0.985$) and perception that program is for women($\chi^2 = 1.67$, $P=0.196$).

Furthermore, the findings show that there is a very strong significant relationship between respondents' sex and some factors affecting male involvement in ANC services as shown by the chi square values and the p-values of less than 0.05 with 1 degree of freedom: traditional beliefs ($\chi^2 = 10.28$, $P=0.001$), distance to ANC centre($\chi^2 = 10.14$, $P=0.001$) and finally lack of finances ($\chi^2 = 15.24$, $P=0.000$).

4.11 Summary of the Chapter

Findings from the informants of the research were presented in the manner that they were obtained from the questionnaires, FGDs, observation or interviews. This was in an attempt to provide a foundation for appropriate interpretation of the results and to determine whether they gave answers to the research questions.

Therefore, in the following Chapter, the discussion of these findings will relate the results to the objectives of the study and try to answer the questions that were posed in the research questions.

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.0 Overview

This chapter presents the discussion of the research findings that were presented in the previous Chapter.

5.1 Introduction

In this chapter, the discussion of these findings will contribute to the understanding of the situation concerning male involvement in antenatal and postnatal care services in Kabwe urban and Chamuka area. This discussion will be based on the research objectives as an attempt to answer the key research questions. It will also seek to establish commonalities between views of different informant groups which in turn will serve as a means of validating the findings of the study.

The main objective of this study was to investigate the factors affecting male involvement in antenatal and postnatal care services, with particular focus on how practical male involvement in maternal health services have been adhered to in Central Province of Zambia. To the best knowledge of the investigator, this was one of the few studies to be conducted in Zambia that encompassed both rural and urban settings.

5.2 Social-Demographic back ground of Respondents.

This part of the chapter gives a discussion on the characteristics of the respondents. Characteristics of the respondents are addressed in terms 5.2.1 to 5.2.6

There are a number of studies done to establish factors relating to poor antenatal and postnatal care attendance in the world. The related factors include place of residence, ethnicity, age, education, employment status, and parity, intention to get pregnant, use of contraceptive method, economic status, health insurance and travel time (McDonald, 1998, Trinh, 2005, Magadi, 2000).

Young women, especially teenagers, are more likely to have unplanned pregnancies, and lack of information and resources to access health services (Mehta, 2002). As regards marital status, single women with unplanned pregnancies, like most pregnant teenagers, may have a negative

attitude towards their pregnancy and, due to this, may be less aware of the signs of pregnancy and as a result seek care much later than would older women (Kogan, et al. 1998).

5.2.1 Sex of respondents

The sex of respondents was vital in coming up with appropriate methods to use in the delivery health services. In terms of sex distribution, most of the respondents from this study were primarily males (122 in number). Most of these respondents were from rural areas (72 in number) as compared to respondents from urban areas (50 in number). While female respondents were only 88 in number and most of these respondents were from urban areas (48 in number) as compared to rural areas (40 in numbers).

5.2.2 Age of Respondents.

Age is important because mothers who are expected to go for antenatal and postnatal care services at any health center of their choice vary by age. In this study, the age group considered was between 18-49 years because it represented the most sexually active age group and was most likely to be in a marital relationship. As stated in item 4.2.1. Of chapter 4, most of respondents (47 in number) were youths that came from the age group of 35-39. Most of the respondents in this age group were from rural areas (26 in number) as compared to respondents from urban area who were only 21 in number. The duration of exposure to risk of pregnancy depends primarily on the age at which women first marry. Zambia Demographic and Health Survey (ZDHS) Report postulates that, overall, among women age 20-49 those who reside in urban areas marry two years later than their counterparts in rural areas (20 and 18 years respectively) (CSO et al., 2007). This was followed by respondents from age group 45-49 (18 in number) and most of the respondents from this age group were from rural areas (14 in numbers) as compared to respondents from urban areas (4 in numbers). There was poor response from this age group because most of them are out of child bearing age (menopause).

The information on respondent's age group was crucial in coming up with strategies of involving men in maternal health services that would cater for all age groups in the study area.

5.3 Knowledge of men in male involvement in ANC and PNC services

The study revealed that the proportion of males who accompanied their spouses for ANC and PNC services was favorably high for ANC services at 79.5 % and for PNC services at 76.0 % respectively. In addition the study revealed that for antenatal care services, the majority of

respondents were from rural areas (57.5 %) as compared to urban respondents (42.5 %), as for postnatal care services the pattern was similar to that of antenatal care (rural area 90.2 % and for urban areas (66.3 %). This study finding is in agreement with the study finding done in Luapula Province of Zambia where 75 % of the clients who attended the clinic at the health Centre came with their husbands (Tshibumbu D, 2006).

However, this study finding is not in consistent with the recent studies that have shown low male involvement in maternal health services. The study done in Gulu district revealed that 48 % of the males accompanied wives during postnatal care services and 65.4 % during antenatal care services (Twehiyo, 2009). Further, the proportion of males who accompanied the wife for PNC in this study finding was higher(76.0 %) than in Northern Tanzania where male involvement was reported to be only 12.5 % (Nsuya et al; 2008). This study also does not agree with the study done in Mbale region in Uganda where only 18 (4.7 %) out of the 387 men had attended antenatal care services with their spouses, but most of them (377 (97 %) out of 387) provided financial support to their spouses to attend antenatal care services (Byamungisha, et al., 2010). Analysis done in respect of residence and male involvement in antenatal care services has shown a strong significant relationship as shown by the chi square value and the p-value of less than 0.05 with 1 degree of freedom($\chi^2 = 5.65$, $P = 0.017$).

Although, male midwives provided maternal health services in the health facilities where this study was conducted, that alone did not change the perception of the community that a labor companion always has to be a woman. These findings concur with the assumptions made by Moser (1993) that reproductive work is almost always the responsibility of women and girls. The traditional ways in which maternal health care services are implemented in the areas where this study was conducted, play a crucial role in influencing male participation in health issues. The entrenched gendered perception of maternal health care services being for women only is indeed reflected in the design of infrastructure for maternal health services in the study areas. This was also another primary source for low male involvement. It was observed during the data collection that the architectural design of the health facilities could not provide privacy for the clients. As a result of such lack of privacy, laboring women were only allowed to have a female labor companion in the labor ward the system which is not in favor of male involvement.

When respondents were asked to state what they thought would help in improving male involvement in maternal health services, the majority of the respondents felt that health centres should be located closer to residences (80.7 %) for easy access of ANC and PNC services. Respondents also felt that there is need to improve IEC system (71.1%), increased sensitization by Community Health care workers (65.8%), Community leaders must be involved in information dissemination to encourage men to get involved (53.5%). Onus is on the government of Republic of Zambia through the ministry of health to implement these suggestions in order to enhance male involvement in maternal health services in Central province.

Similar findings have been documented by Mullick et al., (2005), the social context of the study areas exhibited a culture of silence around pregnancy and childbirth issues. Men were not taught issues related to labor and delivery. This information was given to women only. Men were told how to provide emotional, material and financial support to their pregnant spouses. Gender values and norms in the study area acted to ensure that labor and childbirth knowledge was withheld from men. Similar findings were also documented by Mullick et al., (2005) in a study done in South Africa and (Onyango et al., 2010) in Kenya. The health sector could be the source for maternal health information for men. The health sector should endeavor to invest in IEC strategies that target both men and women for behavior change towards male involvement in maternal health care.

The implications of this study finding at individual level is that all health workers need to put more effort to encourage male participation while as the health system especially the health education need to design messages to encourage male participation in maternal health care services in order to achieve remarkable increased utilization of maternal health care services by women.

According to this study, joint couple decision-making is favorably high in antenatal care and relatively low in postnatal care services. This disparity could be attributed to the government health policy to impose compulsory couple screening during first antenatal booking in all health centers. The findings of this study are relatively similar with the findings of studies done in Kooki, but differ with findings done in Nepal and India. In the study conducted in Kooki area, reported a 7.1 percent joint decision-making on maternal health care services (Bua, 2008), while in Nepal 75 percent of the sampled women reported discussing with their husbands on health issues

during pregnancy(Britta et al;2004), and in India a71 % of joint decision-making in maternal health matters was reported(Frontier,2004).

The comparatively lower level of male involvement in decision-making on maternal health care services in Kabwe district contrasts with that in Nepal and India. This is probably because majority of the respondents in Kabwe district were from rural areas that may hold on the traditional beliefs, low economic activities and long distances to the health centers that do not encourage male involvement in maternal health care services. In addition, the low level of education in Chamuka area amongst couples might also explain the low level of male involvement in decision-making in this study area compared to that in Nepal and India. Studies have shown that educated women are more likely to discuss and make joint decision-making with their spouses on pregnancy health issues than uneducated (Britta et al; 2004).

The low level of male involvement in decision-making on matters related to maternal health care services if not properly addressed will continue to delay referral of the mothers more especially those in labors from home to the health facility because they may need to consult their husbands late when labour begins. The health workers therefore need to encourage inter-spousal communication during sensitization of the community on the importance of male involvement in health related issues such as ANC and PNC services

5.4 Proportion of men involved in ANC and PNC services.

Men's knowledge about male involvement in maternal health care is a starting point for male participation in health issues. However, some men expressed ignorance and others did not understand why they had to be involved. This study revealed that men attending maternal health care services with the wife did not lead to a significant increase in the level of knowledge men had on the recommended minimum of ANC visit, services offered to the women during ANC, delivery and postnatal visits to the health units on the part of men who attended ANC with their partners compared to those who did not attend ANC. The findings of this study is similar to reports of other studies that have shown that even men who attend reproductive health services, they are not directly addressed by the service providers and they end up generally receiving less information on reproductive health and are less prepared in parenting (Finnbogadottir et al; 2003).

Lack of uniform messages and guidelines on the package of care men should receive when they accompany their partners for maternal health care services could be the reason for the low level of knowledge men have about maternal health care services in Central province. When compared residence of respondents and knowledge of men on antenatal care services, the findings show that there is strong significant relationship between residence and knowledge of men on antenatal care services as shown by percentages, chi square values and the p-values of some selected services; family planning (rural 50.8 % and urban 49.2 % , $\chi^2 = 14.00$, $P=0.046$), vaccination (rural 44.1% and urban 55.9 % , $\chi^2 = 16.40$, $P=0.000$) and birth preparedness (rural 57.00 % and urban 43.0 % , $\chi^2 = 10.80$, $P=0.001$).

The findings of this study further show that respondents from urban areas exhibited high levels of knowledge in antenatal care services as compared to their counterparts in the rural areas. This difference could be attributed by so many facilities such as high levels of technologies in urban areas, variety modes of communication to disseminate information, IEC, literature, and social media. Knowledge of male involvement in maternal health services is limited due to facilities which are rarely sourced in rural areas except radios and TVs and few more other means of communication.

The findings of the study could further imply that the health workers in the province do not fully exploit the opportunity provided by the men attending ANC and PNC with their partners to educate women together with their husbands during visitations. The implication of the District Health Board need to clearly identify and provide standard messages which can suit in both urban and rural areas to address men who accompany their partners for maternal health care services. However, the reasons for this difference in level of knowledge between urban and rural area identified in the study will probably be a subject of investigation by future researchers.

5.5 Differentials of male involvement in ANC and PNC between Rural and Urban

According to this study, men who perceived maternal health services as accessible were less likely to accompany the wife for health services. In this study respondents from rural areas were favorably adhered to male involvement as compared to their counter parts in urban areas. The finding of this study differs slightly from other studies that have shown that distances travelled are directly associated with utilization of health services (Muki, 2009). However, the finding in

this study is in agreement with the finding of a study done in Uganda East Africa that revealed that when services are near, men stop accompanying their wives to seek medical care this is the case in Kabwe urban where health services are nearer but with poor response in uptake of health services as compared to Chamuka rural despite health services being long distance located, men are still committed to cover those unbearable distances to access health services. Reporting on their findings, Kasolo and Ampire (2000) illuminated that in Uganda, despite of the health facilities being in walkable distances in many districts, women having income and improvement in the quality of care women continue to report late for ANC and deliver outside the health facilities. This is most likely because most men in Chamuka area view the provision of transport (which in most cases require riding a bicycle) for the wife to the health facility as the reason for accompanying the wife to the health facility yet this ceases to be the case when the health facility is within a walking distance like in Kabwe urban. This finding of the study suggests that if the ministry of health does not sensitize on the benefits of the man accompanying the wife during maternal health care services then the intended benefit of bringing health services near to the people will not achieve all its intended objective of reducing maternal and infant morbidity and mortality by 2015.

The findings of this study further illuminated that a number of the respondents in the study area were involved in polygamous relationship which highly affected male involvement in maternal health services. Therefore, with this background of the study, men in a polygamous relationship were less likely to accompany the wife for health services and this hampered levels of male involvement. This finding is consistent with findings from other studies that have suggested that men in polygamy relationships are always detached from their wives because they are supposed to remain impartial across their marriage (Mullick et al, 2005)

5.6 Attitudes/Perception of spouses on male involvement in antenatal and postnatal care services

The attitudes of men in maternal health services play a critical role in promoting male involvement in antenatal and postnatal services. According to Britta (2004), societal allocation of roles to the men and women especially decision making influences utilization of maternal health services. A study done in Pindu Pakistan revealed that there is a set of gendered beliefs that excludes men from women's domains defines the physiological process for reproduction as

“napaak” (meaning unclean) for 40 days in the post- partum period (Hafeez, 1998). When collected together those gendered norms, values and beliefs will imply that men are largely excluded and ignored from women’s pregnancy related issues, therefore male involvement in maternal health services is highly affected. The findings of this study indicate that prevailing gender roles, norms and values influence male participation in maternal health care services are implemented play a crucial role in influencing male participation as well as knowledge and appreciation of maternal health services. The study illuminates that those norms and values are so much engraved in people’s minds, such that it is difficult for people to break away from them.

Helman (2007) as quoted in Hafeez (1998) asserted that in almost every culture, the main providers of health care are usually women. Such a notion is not uncommon among professional fraternity. With the view that most health care providers are women, the findings of this study have shown that service providers’ attitudes also play a significant role in affecting male involvement. Whilst health care providers have been reported to be receptive to men’s participation in antenatal and postnatal clinics, they have prohibited men’s entry into the labour wards. Furthermore, findings also show that some rural parts of the study area, therefore, accompanying a wife for maternal health care services was viewed by most male participants as a waste of time and money as they could not see its importance. Above all, lack of specific activities for men in the maternal health care services underscored this behavior. The findings further show that gender values and norms in the study area acted to ensure that labor and childbirth knowledge was withheld from men. Findings, further show that most men did not attend antenatal clinics with their wives where health information was disseminated and this could have contributed to their lack of knowledge on issues related to maternal health.

The analysis done on this study in respect of sex and attitude of men towards postnatal care services show that female respondents who strongly agree to ascertain that PNC should only be left to women alone were 15.9 % while men were 10.7 % only. Female respondents who agree to ascertain that PNC services should only be left to women alone were 5.7 % while men were 4.1 % only. Female respondents who strongly agree to ascertain that PNC services should only be left to women alone were 45.5 % while male spouses were 27.9 % only. The male respondents who totally disagree to ascertain that PNC services should only be left to women alone were 52.5 % while female respondents were 33.0 % only.

Further, the findings show that, there is a strong significant relationship between respondents' sex and to ascertain that PNC services should only be left to women alone as shown by the chi square values and the p-values less than 0.05 with a degree of freedom of 4 ($\chi^2 = 14.573$, $P=0.006$).

This study also revealed that men who accompanied the wife for antenatal care services were more likely to accompany the wife for delivery and also more likely to accompany the wife for postnatal care compared to those who did not attend antenatal care services with their wife. A similar finding was reported in a study by Alka and others(2002) done in rural India, they reported that husbands who accompany their wife for routine care in one phase of maternal care are likely to accompany them in the other phases of maternity care. The implication of this study is that the ministry of health need to design messages and package them in simple terms such that all what would be required for the couple to provide in during ANC, delivery and postnatal care services is prepared in time and the couple comes well prepared to avoid surprises that usually keep men away from maternal health care services.

The analysis done in respect of sex and perception of spouses on male involvement illuminated that female respondents who strongly agree that male spouses should be allowed in labour wards were 22.7 % while the male respondents who strongly agree that male spouses should be allowed in labor wards were only 8.2 %. The female respondents who agree that male spouses should be allowed in labor wards were 17.0 % while male respondents who agree that male spouses should be allowed in labour wards were only 7.4 %. The male respondents who were uncertain on the presence of male spouses in the labour wards were 27.0 % while the female respondents who were uncertain with the presence of male spouses in labor wards were only 6.8 %. Female respondents who strongly disagree with the presence of male spouses in labour wards were 30.9 % while the male respondents who strongly disagree with the presence of male spouses in labour wards were only 24.6 %. The male respondents who disagree with the presence of male spouses in labour wards were 32.8 % while the female respondents who disagree allowing male spouses in labour wards were only 22.7 %.

In addition, the findings show that, there is a strong significant relationship between respondents' sex and the presence of male spouses in labour wards during delivery as shown by the chi square values and the p-values of less than 0.05 with a degree of freedom of 5 ($\chi^2 = 27.403$, $P=0.000$).

5.7 Factors associated with male involvement in ANC and PNC services

The study revealed several factors to be associated with men accompanying their partners for maternal health care services. Men who received official invitation letter were more likely to accompany the spouse for ANC and about three (3) times and half time likely to accompany the wife during postnatal compared to men who did not receive official notification more especially during the first booking. It is remarkably possible that official invitation from health providers provided an opportunity to couple communication and negotiation, which has been reported to be positively associated with male involvement in health issues(Britta et al;2006).

The findings of this study suggests the official invitation letter for the husband to attend ANC and PNC services with the wife should be made part and parcel of the package that a pregnant woman must receive during the first contact with maternal health care services providers(first booking). Men who perceived their culture not prohibitive of the man accompanying the wife during ANC were more likely to accompany the wife for ANC compared to men whose culture was prohibitive. The finding of this study is consistent with the findings of other studies carried out in South Africa in 2005. In South Africa, service providers had a concern that a man may lose strength when he sees a naked woman for maternal health service (Mullick et al; 2005). This was noted to contribute to some men's not accompanying the spouses for maternal health services. Health service providers need to sensitize the community and dispel some of these retrogressive culturally held beliefs that discourage male involvement in maternal health care services.

In this study, short waiting time at the health facility was predictive of increased male involvement in accompanying the wife for health care services. The findings of this study is in agreement with the findings from several studies that have reported long waiting time at the health facility as being one of the reasons for low male involvement in accompanying their partners for maternal health services(Mullick et al, 2005). It is possible that if waiting time at the health facility were reduced it will result in increased male accompanying the wife and child for postnatal care. This is because many men have long working hours and long waiting time makes it difficult to find off time to attend maternal health services. The implication of the finding is that we need to increase on the number of the health workers in the health facilities, if we are to achieve waiting time at the health facilities of less than 30 minutes when spouses are attending maternal health care services.

From quantitative data, analysis done using Pearson Chi-square only economic activities of respondents and residential areas were found to be remarkably significant in affecting levels of male involvement in maternal health services. Education attainment of spouses shows no significant relationship in male involvement. The finding of this study does not concur with the findings in the studies carried out in Uganda and Kenya. In Kenya, uneducated men were found to be less likely to participate in reproductive health. The study in Uganda revealed that educated men were positively associated with male participation in health services. Reporting their findings of their study in Uganda, Byamungisha and others reported that men who had 8 or more years of education were 2 times more likely to get involved in maternal health care than those with less education (Byamungisha, et al., 2010). Studies suggest that uneducated men tend to hold on traditional beliefs which greatly impair inter spousal communication leading to low male involvement in reproductive health (Nzioka, 2001) as quoted in Britta and others (2006).

According to this study, lack of drugs and supplies in the government health facilities was another reason given by male spouses for not accompanying the wives for health services. Ruwenza and others (2009) reported similar findings of household paying for health care in Jinja district. The same study also reported that health workers told their clients who came for health care in the government health facilities that there were no drugs at the health facility but on making payments, drugs suddenly became available (Ruwenza et al, 2009). This is consistent with the findings of this study, where men in FGDs complained of lack of drugs and supplies in the government health facilities in Central Province as a reason of low male involvement in health services. In this study poverty could be a major bottleneck to men accompanying their partner for fear of being ridiculed and embarrassed in case they fail to pay for supplies like gloves that the health workers demand during antenatal or delivery.

In this study, distance to the health care facility compounded with lack of financial resources was perceived as a challenge to male involvement in health issues. This finding is consistent with other similar studies done in Tanzania, Uganda and Bangladeshi (Twaheyo et al., 2010) as quoted in Nzioka (2001). Thaddeus and Maine (1994) illuminated that long distance to a health facility is one of the most important determinants in the decision not to seek modern health care even when needed. The health sector should endeavor to invest in community based male involvement and maternal health care approaches that have proved successful elsewhere.

In a similar study done in Kalabo district of Zambia on maternal health services indicated that, distance is a significant factor affecting delay to decide to seek care from health facility. It also influences the delay caused by the travel time from home to the clinic. The geographical features of Kalabo district, the uneven distributions of facilities and the absence of any roads or transport systems were also challenges to maternal health service utilization (Stekelenburg et al, 2004).

According to this study, poor attitude of health workers and fear of being harassed by health workers were some of the reasons cited to be contributing to low male involvement in maternal health care services. The finding of this study is consistent with other studies done in Kenya where poor behavior of service providers has been found to adversely affect male partner's capacity to use reproductive health services (Alka et al, 2005). This is probably because men fear being the subject of verbal and emotional controversy and this prevent men from being involved in health care services.

In a similar study done by Dennis et al 1995 in Uganda, some women stated that the reasons affecting their poor maternal health services attendance were the long waiting hours, inconvenient service hours and that they were not treated well by the service providers. The judgmental nature of some health workers towards pregnant adolescents may negatively influence pregnant teenagers' efforts to attend antenatal and postnatal services (Nicholus, 1997) as quoted in Nyane (2007)

According to this study, the fact that health workers don't allow men entry into the maternity ward may be responsible for some men not accompanying their partners for maternal health services. Similar findings were reported in the study carried out in South Africa. In South Africa, some men indicated that even when men accompanied their partners to the clinic, they generally waited from outside (Mullick 2005). These findings imply that much as we are advocating for increased male involvement in maternal health, the health facility system has not yet been prepared to accommodate men who accompany their wives for maternal health care services.

This study revealed lack of knowledge of what roles the man is to play during postnatal care, belief that man's role is to provide transport and checking on the child health card was cited as the reason why some men do not accompany the wife and child for postnatal care. The findings of this study is consistent with several other studies that have reported that even when men

encourage their partners to seek health care and get involved there is still lack of information on postnatal care services for men.

Social economic status of the respondents in this study was perceived to be a challenge to male involvement in health issues. This is consistent with the finding of this study that have reported that due to social economic difficulties, men did not have time to attend to maternal health services for they struggle to look for money to provide for their families. Reporting their findings of their studies Pagel et al (1990) and Mutale et al (1991) illuminated that lack of social support, especially from the husbands has negative effects on fetal growth.

This study finding revealed that men who reported making a joint decision on ANC were more likely to make a joint decision on postnatal care. The finding of this study is consistent with finding in India that reported that men who were involved in one phase of maternal health care were most likely to be involved in other phases of maternal health (Alka et al, 2002). In this study, men who shared problems with their partners were twice more likely to make a joint decision on issues concerning maternal health care. Similar findings were reported in the study carried out in Nepal in 2003. In Nepal, women who shared with the husbands were more likely to experience several male involvements in health seeking behaviors (Britta, 2004).

The finding from FGD confirm the above in that majority of the male participants in this study considered antenatal care as a woman's issue and considered checking on the health card as the only responsibility to confirm if the wife actually went to the facility for antenatal care. The findings of this study suggest that the level of male involvement in health services offered during antenatal care in Central Province is still very low.

Understanding the strategies that health care providers should employ in order to invite more men to participate in antenatal and postnatal care services is very vital especially in today's dynamic cultural environment. Effective utilization of such strategies is dependent on uncovering the salient issues that facilitate male involvement in maternal health services. Evidence from FGDs showed that men in all age groups were strongly in favor of their wives having ANC care and a hospital delivery and felt that it could be beneficial to accompany them despite rarely doing this in practice.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 INTRODUCTION

This chapter presents the conclusion and recommendations of the research discussions that were presented in the previous chapter.

6.1 Conclusion

Although a high proportion of male spouses in Central Province are aware of ANC and postnatal care services, the number of male spouses who actually accompany their partners for ANC and delivery was remarkably low as compared to the attendance for postnatal care services.

Men are willing to be involved in the maternity and postnatal care of their pregnant partners. It is feasible to this in the health facilities; however there are a number of challenges that must be addressed, including cultural influences, socio-economic status, and education status of male spouses, men not able to take time off work and health provider attitudes. Other salient factors highlighted in the study to affect male involvement are; long distance covered to health centres, waiting time at health centre, lack of privacy at health centres, poor inter spousal communication and travel cost to health centres. Involving men will not only improve mother's and babies' health but also affect men's need for reproductive health.

The prevailing gender role norms remarkably influence male participation in maternal health care. The gender roles and norms are also reflected in maternal health delivery system in the rural health facilities in Chamuka area where by services are female focused. This poses a mammoth challenge to the health providers as regards to male involvement in antenatal and postnatal care services. However, male involvement in maternal health care is possible if the causes of challenges were quickly surmounted. Maternal health care needed to be de-feminized in order to create a foundation for a more equal access to services for both men and women. In addition, pregnancy and child birth education need to be given to both men and women so that they are equally knowledgeable and fully involved in issues pertaining to maternal health services.

Men who attended health services with their partners did have a significantly higher level of knowledge on maternal health care services compared to men who did not attend health services with their partners. Society also frowns upon a man visiting maternal health services with his wife saying that he was very possessive. The men that actually visit the clinics find them not so male –friendly. Thus they get intimidated. However, establishing the contributing factors to the finding need to be further investigated to establish the messages health workers need to give to the men who attend health services with their spouses.

6.2 Recommendations.

In order for male involvement in the maternity care of their partners to be a success the following challenges need to be addressed convincingly.

1. The Central Province Health Board together with the Ministry of Health should take steps to raise awareness on the importance and benefits of male involvement in maternal health care services. This could be achieved through the issuing of invitation letters for men who attend maternal health care services with their partners, designing messages that specifically target male spouses who accompany their spouses for maternal health care services and the involvement of the community health teams and community leaders in reaching out to men and encourage their involvement in maternal health care services.
2. Undertake wider community outreach so that more men can be persuaded to participate in their partners' maternal health care.
3. Develop ways to disseminate information that are acceptable and appropriate for the target group, both men and women.
4. Work with the health system should improve conditions such as lack of privacy that make it difficult for husbands to participate, and identify other ways health staff could encourage male spouses to be present.
5. The health sector should endeavor to invest in Information Education and Communication (IEC) strategies that target both men and women for behavior change towards male involvement in maternal health care in both urban and rural areas.
6. The health system should strategically target the most socializing agents such as parents, communities, teachers, churches and the mass media to reinforce male participation in maternal health services in both rural and urban settings of Central province of Zambia.
7. The service providers to make sure that there is a serious campaign involving both rural and urban areas to fill the information gap.

8. There should be a couple level approaches to focus on couples as a unit rather than one at a time. Couple oriented counseling stresses an equal responsibility in maternal health. In relation to the preceding recommendation, it would be imperative for family planning clinics to consider flexible hours for couple counseling taking into account men's work schedule.
9. ANC and PNC clinics should introduce a Father's Day where it is mandatory that a couple attend one session together. This will act as a platform to increase male involvement. It will also afford men to get first hand information from the medical personnel on the health status of their wives and what they should do to safe guard their health.
10. Improving interpersonal skills of the health care providers using information about how community (women and men) defines care. There may be need for closed sessions among the male leaders and community leaders when discussing cultural or traditional issues that infringe on reproductive health.
11. Existing health services should be made more "male- friendly", with service providers undergoing symposium training and engaging in effective out-reaches activities.
12. There is need to incentivize male spouses who successfully accompany their spouses. The incentive can be in form of allowances agreed upon by the Ministry of Health and the community.

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APPENDICES

APPENDIX ONE: QUESTIONNAIRES

Questionnaire for spouses

I am a postgraduate student at the University of Zambia pursuing a Master of Population Studies Degree who is carrying out a research on **Factors affecting Male involvement in the Antenatal Care (ANC) and Post-Natal Care (PNC) services. A case of Kabwe urban and Chamuka areas of Central Province.** I kindly request you to fill in the necessary information on the questions raised in this questionnaire. Be assured that all the information you give me will be treated confidentially and will be used for academic purposes only.

Tick (v) in the appropriate boxes and provide answers in the given lines.

Section A: Background Information

01. Sex 1. Male ☐ 2. Female ☐
02. Age ☐
03. Marital Status 1. Single ☐ 2. Married ☐ 3. Divorcee ☐
4. Widow ☐ 5. Widower ☐
04. Economic activities ☐ 1. Public Sector ☐ 2. Self Employed
3. Unemployed ☐ 4. Home duties ☐ 5. Retired ☐
6. Student ☐ 7. Farming ☐ 8. Trading ☐
9. Others
Specify
05. Highest Level of Educational attainment.....1. None ☐ 2. Primary ☐
3. Secondary ☐ 4. Tertiary ☐
06. Residential..... 1. Rural ☐ 2. Urban ☐
07. Name of Local Community.....

08	Can you read and understand a letter or a magazine, easily, with difficult or not at all?	Easily 1 With difficult 2 Not at all 3																					
09.	How often do you read a newspaper or magazine or book?	Everyday 1 at least once per week 2 At least once per month 3 Never 4																					
10.	How often do you listen to the radio?	Everyday 1 at least once per week 2 At least once per month 3 Never 4																					
11.	Does your household have/own any of the following facilities? (Tick all Appropriate)	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Radio</td> <td>1</td> <td>2</td> </tr> <tr> <td>Television</td> <td>1</td> <td>2</td> </tr> <tr> <td>Bicycle</td> <td>1</td> <td>2</td> </tr> <tr> <td>Motorcycle</td> <td>1</td> <td>2</td> </tr> <tr> <td>Car</td> <td>1</td> <td>2</td> </tr> <tr> <td>Phone</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		Yes	No	Radio	1	2	Television	1	2	Bicycle	1	2	Motorcycle	1	2	Car	1	2	Phone	1	2
	Yes	No																					
Radio	1	2																					
Television	1	2																					
Bicycle	1	2																					
Motorcycle	1	2																					
Car	1	2																					
Phone	1	2																					
12.	How often do you watch TV?	Everyday 1 At least once per week 2 At least once per month 3 Never 4																					
13.	What is your religion?	Catholic 1 Protestant 2 Moslem 3 Other _____ 4 (specify)																					
14.	How often do you attend worship services?	Everyday 1 at least once per week 2 At least once per month 3 Never 4																					
15.	How important is religion in your life?	Very important 1 Important 2 Not important 3 Other _____ 4 (specify)																					

SECTION B: KNOWLEDGE ON MALE INVOLVEMENT ON ANC SERVICES																					
Now I will ask you questions on knowledge of men in ANC services																					
16.	Have you ever heard of ANC services?	Yes No	1 2																		
17.	Have you ever shared information about ANC services with the following	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>Family members</td> <td>1</td> <td>2</td> </tr> <tr> <td>Health workers</td> <td>1</td> <td>2</td> </tr> <tr> <td>Community members</td> <td>1</td> <td>2</td> </tr> <tr> <td>Religious members</td> <td>1</td> <td>2</td> </tr> </table>		Yes	No	Family members	1	2	Health workers	1	2	Community members	1	2	Religious members	1	2				
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Health workers	1	2																			
Community members	1	2																			
Religious members	1	2																			
18.	Which services in ANC do you know? (Tick all Appropriate)	<table border="0"> <tr><td>Family planning</td><td>1</td></tr> <tr><td>Immunization</td><td>2</td></tr> <tr><td>Vaccination</td><td>3</td></tr> <tr><td>Birth preparedness</td><td>4</td></tr> <tr><td>Health promotion</td><td>5</td></tr> <tr><td>Early detection of complication and prompt of treatment</td><td>6</td></tr> <tr><td>Counselling</td><td>7</td></tr> <tr><td>Others _____</td><td>8</td></tr> </table>	Family planning	1	Immunization	2	Vaccination	3	Birth preparedness	4	Health promotion	5	Early detection of complication and prompt of treatment	6	Counselling	7	Others _____	8			
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Health promotion	5																				
Early detection of complication and prompt of treatment	6																				
Counselling	7																				
Others _____	8																				
19.	Which ANC services have you/ your spouse ever used? (Tick all Appropriate)	<table border="0"> <tr><td>Family planning</td><td>1</td></tr> <tr><td>Immunization</td><td>2</td></tr> <tr><td>Vaccination</td><td>3</td></tr> <tr><td>Birth preparedness</td><td>4</td></tr> <tr><td>Health promotion</td><td>5</td></tr> <tr><td>Early detection of complication and prompt of treatment</td><td>6</td></tr> <tr><td>Counselling</td><td>7</td></tr> <tr><td>Disease presentational treatment among pregnant women</td><td>8</td></tr> </table>	Family planning	1	Immunization	2	Vaccination	3	Birth preparedness	4	Health promotion	5	Early detection of complication and prompt of treatment	6	Counselling	7	Disease presentational treatment among pregnant women	8			
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Disease presentational treatment among pregnant women	8																				
20.	Which ANC services do men know? (Tick all Appropriate)	<table border="0"> <tr><td>Family planning</td><td>1</td></tr> <tr><td>Immunization</td><td>2</td></tr> <tr><td>Vaccination</td><td>3</td></tr> <tr><td>Birth preparedness</td><td>4</td></tr> <tr><td>Health promotion</td><td>5</td></tr> <tr><td>Early detection of complication and prompt of treatment</td><td>6</td></tr> <tr><td>Counselling</td><td>7</td></tr> <tr><td>Disease presentational treatment among pregnant women</td><td>8</td></tr> <tr><td>Others _____</td><td>9</td></tr> </table>	Family planning	1	Immunization	2	Vaccination	3	Birth preparedness	4	Health promotion	5	Early detection of complication and prompt of treatment	6	Counselling	7	Disease presentational treatment among pregnant women	8	Others _____	9	
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Disease presentational treatment among pregnant women	8																				
Others _____	9																				
21.	Have these ANC services been available in this community in the past 5 years?	Yes No	1 2																		
22.	How did you first get to know about the ANC Services?	<table border="0"> <tr><td>Media (Radio, News Papers, TV)</td><td>1</td></tr> <tr><td>Friends</td><td>2</td></tr> <tr><td>Bill Boards</td><td>3</td></tr> <tr><td>Posters</td><td>4</td></tr> <tr><td>Flyers</td><td>5</td></tr> </table>	Media (Radio, News Papers, TV)	1	Friends	2	Bill Boards	3	Posters	4	Flyers	5									
Media (Radio, News Papers, TV)	1																				
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Posters	4																				
Flyers	5																				

	(Tick all Appropriate)	Health workers 6 Church members 7 Others _____ 8
23.	When was your last time you heard about the ANC services?	One Week ago 1 More than 2 weeks ago 2 One month ago 3 More than three months ago 4 Twelve months ago 5
24.	In the past five years, have you/spouse been pregnant?	Yes 1 No 2
25.	When you/your spouse were pregnant, did you/your spouse visit the ANC health services?	Yes 1 No 2
26.	Which services did you use? (Tick all Appropriate)	Family planning 1 Immunization 2 Vaccination 3 Birth preparedness 4 Health promotion 5 Early detection of complication and prompt of treatment 6 Counselling 7 Disease presentational treatment among pregnant women 8
27.	Are the Health centres close to your community?	Yes 1 No 2
28.	Have you/your spouse ever accompanied you for ANC services?	Yes 1 No 2
29.	How often does your spouse accompany you to ANC services?	Always 1 Some times 2 Never 3
30.	During the ANC visit, were you given information on maternal and child health?	Yes 1 No 2
31.	Under what circumstances did you/your spouse accompany you? (Tick all Appropriate)	Family Planning 1 Birth preparedness 2 Counselling 3 Subsequent medical checkups 4 HIV testing Others _____ 5
32.	Do men know the ANC services in your community?	Yes 1 No 2
33.	What are the benefits of male involvement in use of ANC services? (Tick all Appropriate)	Financial support 1 Material support 2 Moral support 3 Child spacing 4 Under standing 5 Use of condoms 6

34.	Are there some ANC services that you avoided using	Yes	1
		No	2
35.	Which ones have you avoided and why?.....		
	Now i will ask you Questions on knowledge of men in PNC services		
36.	Do you know any PNC services?	Yes	1
		No	2
37.	What do you know about PNC services ? (Tick all Appropriate)	Family planning	1
		Immunization	2
		Vaccination	3
		Birth preparedness	4
		Health promotion	5
		Early detection of complication and prompt of treatment	6
		Counselling	7
		Others_____	8
38.	Have you ever heard of PNC services in your area?	Yes	1
		No	2
39.	Have you ever shared information about PNC services with the following?		Yes No
		Family members	1 2
		Health workers	1 2
		Community members	1 2
		Religious members	1 2
40.	Which PNC services have you/ your spouse ever used? (Tick all Appropriate)	Family planning	1
		Immunization	2
		Vaccination	3
		Birth preparedness	4
		Health promotion	5
		Early detection of complication and prompt of treatment	6
		Counselling	7
		Others_____	8
41.	Which PNC services do men know? (Tick all Appropriate)	Family planning	1
		Immunization	2
		Vaccination	3
		Birth preparedness	4
		Health promotion	5
		Early detection of complication and prompt of treatment	6
		Counselling	7
		Others_____	8
42.	Have these PNC services been available in this community in the past 5 years?	Yes	1
		No	2

43.	How did you first get to know about the PNC Services? (Tick all Appropriate)	Media (Radio, News Papers, TV) 1 Friends 2 Bill Boards 3 Posters 4 Flyers 5 Health workers 6 Church members 7 Others _____ 8 (SPECIFY)																					
44.	When was your last time you heard about the PNC services?	One Week ago 1 More than weeks ago 2 One month ago 3 More than three months ago 4 Twelve months ago 5																					
45.	In the past five years, have you/spouse been pregnant?	Yes 1 No. 2																					
46.	When you/your spouse had a child, did you/your spouse visit the PNC health services?	Yes 1 No. 2																					
47.	Are there some PNC services that you avoided using?	Yes 1 No 2																					
48.	Have you/your spouse ever accompanied you for PNC services?	Yes 1 No 2																					
49	During the PNC visit, were you given information on any of these? (Tick all Appropriate)	<table border="1"> <thead> <tr> <th></th> <th>yes</th> <th>no</th> </tr> </thead> <tbody> <tr> <td>VCT</td> <td>1</td> <td>2</td> </tr> <tr> <td>Family Planning</td> <td>1</td> <td>2</td> </tr> <tr> <td>Under five clinic</td> <td>1</td> <td>2</td> </tr> <tr> <td>Immunization</td> <td>1</td> <td>2</td> </tr> <tr> <td>Counselling</td> <td>1</td> <td>2</td> </tr> <tr> <td>Others _____</td> <td></td> <td></td> </tr> </tbody> </table>		yes	no	VCT	1	2	Family Planning	1	2	Under five clinic	1	2	Immunization	1	2	Counselling	1	2	Others _____		
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Immunization	1	2																					
Counselling	1	2																					
Others _____																							
50.	Are there some PNC services that you avoided using	Yes 1 No 2																					
51.	Which ones have you avoided and why?.....																						
SECTION C: ATTITUDES OF MALE INVOLVEMENT IN ANC AND PNC SERVICES Now I will ask you questions on attitudes of men in ANC services																							
52.	Have men in the past five years changed their attitudes towards their wives when they are pregnant?	Yes 1 No. 2																					
53.	How are attitudes of men on ANC services in this community?	Very good 1 Good 2 Moderate 3																					

		Bad 4 Very bad 5
54.	What do you think is causing the change of attitudes in male involvement in ANC services in your community? (Tick all Appropriate)	Lack of time 1 Economic 2 Traditional beliefs 3 Distance to ANC centre 4 Shortage of drugs. 5 Attitudes of health workers. 6
55.	Are men involved in ANC services in your community?	Yes 1 No. 2
56.	In which services are men mostly involved? (Tick all Appropriate)	Family Planning 1 Counselling 2 Health Promotion 3 Birth Preparedness 4 Disease Prevention 5 Immunisation 6 VCT Testing 7 Others _____ 8
57.	In which services are females mostly involved? (Tick all Appropriate)	Family Planning 1 Counselling 2 Health Promotion 3 Birth Preparedness 4 Disease Prevention 5 Immunisation 6 VCT Testing 7 Others _____ 8
58.	How are attitude of community in male involvement in ANC?	Positive 1 Negative 2 Neutral 3
59.	When you went for ANC services were you welcome?	Yes 1 No 2
60.	How was the attitude of health workers towards male involvement in ANC services at your health centre?	Improving 1 Worsening 2 Same 3
61.	If you or your spouse got pregnant, would you be willing to visit ANC health services?	Yes 1 No 2
62.	Do men value the ANC services in your Community?	Yes 1 No 2
63.	What are men's feelings towards ANC services in this community?	Very good 1 Good 2 Neutral 3 Very bad 4 Bad. 5

64.	Are men's beliefs towards ANC services affected by the traditional beliefs?	Yes 1 No 2
65.	The last time you attended ANC sessions how long was the session?	Within 30 minutes 1 1 hour 2 2 hours 3 More than 2 hours 4
66.	What should be done to improve male involvement in ANC services? (Tick all Appropriate)	Empower families with small loans 1 Improve IEC systems e.g. Chiefs, headmen, Mps Councillors 2 Community health workers 3 Improve attitude of health workers 4 Others (specify).....5
67.	What things encourage men to participate in the utilisation of ANC services? (Tick all Appropriate)	Giving small loans to men 1 Constant supply of drugs 2 Quick and better services 3 Giving first priorities to men 4
68.	What things prohibit or prevent men to be involved in ANC services? (Tick all Appropriate)	Economic crisis 1 Stigma 2 Distance to healthy centres 3 Lack of drugs 4 Negative attitude of healthy workers 5
To what extent do you agree or disagree with the following statements?		
69.	ANC services should only be left to women alone?	Strongly agree 1 Agree 2 Uncertain 3 Strongly disagree 4 Disagree 5
70.	Male spouses should be allowed in the labour ward to support their wives during delivery.	Strongly agree 1 Agree 2 Uncertain 3 Strongly disagree 4 Disagree 5
71.	The government of Zambia needs to introduce paternity leave for male spouses in order to enable them take care of their wives when they reach their second trimester of their pregnancy.	Strongly agree 1 Agree 2 Uncertain 3 Strongly disagree 4 Disagree 5
Now I will ask you question on attitudes of men on PNC services.		
72.	Have men in the past five years changed their attitudes towards their wives when they have a child?	Yes 1 No. 2

73.	How are attitudes of men on PNC services in this community?	Very good 1 Good 2 Moderate 3 Bad 4 Very bad 5
74.	What do you think is causing the change of attitudes in male involvement in PNC services in your community? (Tick all Appropriate)	Lack of time 1 Economic 2 Traditional beliefs 3 Distance to PNC centre 4 Shortage of drugs. 5 Bad attitudes of health workers. 6 Others _____ 7
75.	Are men involved in PNC services in your community?	Yes 1 No. 2
76.	In which services are females involved most? (Tick all Appropriate)	Family Planning 1 Counselling 2 Health Promotion 3 Birth Preparedness 4 Disease Prevention 5 Immunisation 6 Others _____ 7
77.	How are attitudes of community in male involvement in PNC?	Positive 1 Negative 2 Neutral 3
78.	When you went for PNC services were you welcome?	Yes 1 No 2
79.	How was the attitude of health workers towards male involvement in PNC services?	Improving 1 Worsening 2 Same 3
80.	If you or your spouse had a child, would you be willing to visit PNC health services?	Yes 1 No 2
81.	What are men's feelings towards PNC services in this community?	Very good 1 Good 2 Neutral 3 Very bad 4 Bad. 5
82.	Are men's beliefs towards PNC services affected by the traditional beliefs?	Yes 1 No 2
83.	The last time you attended PNC sessions how long was the session?	Within 30 minutes 1 1 hour 2 2 hours 3 More than 2 hours 4
84.	What should be done to improve male involvement in PNC services?	Empower families with small loans 1 Improve IEC systems e.g. Chiefs,

	(Tick all Appropriate)	headmen, Mps Councillors 2 Community health workers 3 Improve attitude of health workers 4 Others (specify)..... 5
85.	What things encourage men to participate in the utilisation of PNC services? (Tick all Appropriate)	Giving small loans to men 1 Constant supply of drugs 2 Quick and better services 3 Giving first priorities to men 4
86.	What things prohibit or prevent men to be involved in PNC services? (Tick all Appropriate)	Economic crisis 1 Stigma 2 Distance to healthy centres 3 Lack of drugs 4 Negative attitude of healthy workers 5
To what extent do you agree or disagree with the following statements?		
87.	PNC services should only be left to women alone	Strongly agree 1 Agree 2 Uncertain 3 Strongly disagree 4 Disagree 5
88.	The government of Zambia needs to introduce paternity leave for male spouses in order to enable them take care of their wives after they have delivered.	Strongly agree 1 Agree 2 Uncertain 3 Strongly disagree 4 Disagree 5
89.	Male spouses should be allowed in the labour ward to support their wives during delivery.	Strongly agree 1 Agree 2 Uncertain 3 Strongly disagree 4 Disagree 5
SECTION D:PRACTICE;LEVELS OF MALE INVOLVEMENT IN ANC/PNC SERVICES Now i will ask you Questions on male involvement in ANC services		
90.	Do you attend ANC services with your spouse?	Yes 1 No 2
91.	If you do how often?	Always 1 Sometimes 2 Rarely 3
92.	If you don't why? (Tick all Appropriate)	Facility too far 1 Busy 2 Health workers not friendly 3 No Interest 4 Programme is for women 5 Lack of awareness 6 Others specify7

93.	Do you practice what you learn during ANC services?	Yes No.	1 2
94.	Do healthy workers make follow ups to the spouses after ANC sessions?	Yes No.	1 2
95.	Do you/your spouse give you assistance when you go for ANC services?	Yes No	1 2
96.	If you do what type of assistance do you render? (Tick all Appropriate)	Economic Moral Support Accompany Sharing health information	1 2 3 4
97.	For what services do men accompany their spouses? (Tick all Appropriate)	Counselling VCT testing Immunization Family Planning Birth preparedness	1 2 3 4 5
98.	Are men involved in ANC services?	Yes No	1 2
99.	For which services are they involved?	Counselling VCT testing Family Planning Birth preparedness	1 2 4 5
100.	What challenges do men face when they accompany their spouses for ANC services?	Shyness Stigma Traditional beliefs Distance to ANC centres Programme is for women Lack of finances	1 2 3 4 5 6
101	In what ways should men help their spouses during ANC services?	Accompany Encouragement Financial support Moral support Granting permission	1 2 3 4 5
Now i will ask you Questions on male involvement in PNC services			
102	Do you always attend PNC services with your spouse?	Yes No	1 2
103	If you do, how often?	Always Sometimes Rarely	1 2 3
104.	If you don't why? (Tick all Appropriate)	Facility too far Busy Health workers not friendly No Interest Programme is for women Lack of awareness Others_____	1 2 3 4 5 6 7

105.	Do you put into practice what you learn during PNC sessions?	Yes No	1 2
106.	Do you/your spouse give you assistance when you go for PNC services?	Yes No	1 2
107.	If you do what type of assistance do you give?	Economic Moral Support Accompany Sharing health information Others_____	1 2 3 4 5
108.	For what services do men follow at PNC centre? (Tick all Appropriate)	Counselling VCT testing Family Planning Under five clinic Others_____	1 2 3 4 5
SECTION E: FACTORS AFFECTING MALE INVOLVEMENT IN ANC/PNC SERVICES Now i will ask you Questions on factors affecting male involvement in ANC services			
109.	Are ANC services readily available in your community?	Yes No	1 2
110.	Which ANC services are readily available? (Tick all Appropriate)	Family planning Immunization Vaccination Birth preparedness Counselling Others_____	1 2 3 4 5 6
111.	Which ANC services do you feel comfortable to visit with your spouse? (Tick all Appropriate)	Counselling VCT testing Family Planning Birth preparedness Immunization Others_____	1 2 3 4 5 6
112.	Are you able to support your spouse during ANC service?	Yes No	1 2
113.	What challenges do men face when they accompany their spouses for ANC services? (Tick all Appropriate)	Shyness Stigma Traditional beliefs Distance to ANC centres Programme women is for Lack of finances Others_____	1 2 3 4 5 6 7
114.	What mode of transport do you use to seek ANC services? (Tick all Appropriate)	Walking Bicycle Motor cycle Vehicles	1 2 3 4
115.	When you/your spouse visited ANC centres did you/your spouse face challenges?	Yes No	1 2

116.	What factors affected you/your spouse at ANC centre? (Tick all Appropriate)	Attitude of health workers 1 Shyness 2 Stigma 3 Traditional beliefs 4 Perception from the community 5 Others _____ 6
117.	Do you think men in rural areas are more involved in ANC services than those in urban areas, and why? _____	Yes 1 No 2
Now i will ask you Questions on factors affecting male involvement in PNC services		
118.	Are men willing to support their spouses during PNC services	Yes 1 No 2
118.	Which PNC Services do you feel comfortable to visit with your spouse? (Tick all Appropriate)	Family planning 1 Immunization 2 Vaccination 3 Under five clinic 4 Counselling 5
119.	What challenges do men face when they accompany their spouses for PNC services? (Tick all Appropriate)	Shyness 1 Stigma 2 Traditional beliefs 3 Distance to ANC centres 4 Programme women is for 5 Lack of finances 6
120.	Are PNC services located within your locality?	Yes 1 No 2
121.	What mode of transport do you use to seek PNC services?	Walking 1 Bicycle 2 Motor cycle 3 Vehicles 4 Others _____ 5
122.	How often do you use this mode of transport?	Always 1 Sometimes 2 Rarely 3
123.	What factors affected you/your spouse at PNC centre? (Tick all Appropriate)	Attitudes of health workers 1 Shyness 2 Stigma 3 Traditional beliefs 4 Lack of drugs 5

124.	<p>Which of the following factors can prevent you/your spouse from getting PNC service or treatment from health centre)</p> <p>(Tick all Appropriate)</p>	<p>Getting permission for treatment 1</p> <p>Getting money for treatment 2</p> <p>Distance to a health facility 3</p> <p>Not willing/wanting to go alone 4</p> <p>Concerns that there may not be a health provider 5</p> <p>Concerns that there may be no Drugs available 6</p> <p>Others_____ 7</p>
125.	<p>What should be done to improve male involvement in PNC services?</p> <p>(Tick all Appropriate)</p>	<p>Empower families with small loans 1</p> <p>Improve on IEC 2</p> <p>Community health workers to sensitize information on PNC 3</p> <p>Community leaders e.g. chiefs, headmen, Mps, Councillors to disseminate information on PNC services. 4</p> <p>Health centre should be located closer to locality 5</p> <p>Others_____ 6</p>

APPENDIX TWO: IN-DEPTH INTERVIEWS

INTERVIEW GUIDE FOR MINISTRY OF HEALTH OFFICIALS/CLINICAL OFFICERS/HEALTH CENTRE ADMINISTRATORS/SISTERS IN CHARGE

I am Mweemba Chris studying at the University of Zambia, I am pursuing a master of population studies programme. I am conducting a Research on male involvement in Ante Natal Care (ANC) and Post Natal Care (PNC) services in Kabwe urban and chamuka areas of central province.

You are kindly requested if you can be a stake holder in this research. I will greatly appreciate if you could spend a few minutes of your valuable time to be part of the interview. Be assured that the information you supply will be treated with utmost confidentiality and is purely your academic purposes.

Section A

1. Position.....
2. Department/Area of specialization.....

Section B

1. What is the nature of your job?
2. Do you know ante natal care services?
3. Do community members know availability of ANC/PNC services?
4. How did they know it?
5. What are antenatal care services?
6. What are the ANC services offered by your centre?
7. Is there a national health policy on male involvement in ANC services to guide and regulate ANC services?
8. How often do you use ANC/PNC guidelines at this centre?
9. What would you ascribe to the low participation of men in ANC services?
10. What suggestions do you have to improve male involved in ANC services?
11. What do you understand of PNC services?
12. Do men accompany their spouses for PNC services?
13. What do you do to encourage male involvement in PNC services?

14. What factors prohibit or facilitate male involvement in PNC services?
15. What kind of support should men give to their spouses during PNC services?
16. What are the PNC services offered at your center?
17. Does your center provide natural environment for spouses to discuss PNC services?
18. What are the benefits of male involvement in PNC services?
19. Are the participants encouraged to practice what they learn in PNC sessions?
20. How would you describe the male participation in PNC services here, and why?
21. How often do you receive couples for PNC services?
22. Do you think the current health policy on male involvement in PNC services can be upheld?
23. How often are the PNC sessions conducted at your center?
24. Do you make follow ups for the couples after PNC sessions?
25. If you do make follow ups, how often?
26. Do you offer any outreach programs on ANC/PNC services?
27. Does your centre offer special trainings in ANC/PNC for spouses in your community?
28. If you do, how often and how do you do it?
29. Do you offer orientation/refresher courses on ANC/PNC services to the community?
30. What are the attitudes of the health workers at your centre to couples who seek for PNC services?
31. What roles should the following do to enhance male participation in provision of and use of ANC/PNC services?
 - (a) Religious leaders
 - (b) Community leaders (eg. NCH, and CHW chairpersons).
 - (c) Traditional leaders (eg. Chiefs, headmen).
 - (d) Civic leaders (eg. MPs, Councilors).
32. After delivery do mothers come back for postnatal care services?
33. How long does it take for mothers to come back for PNC services?
34. Are mothers accompanied by their spouses during post natal care services?
35. In what ways are men involved in PNC services?
36. How do you encourage men to accompany their spouses for PNC services?
37. What could be the reasons why men do not accompany their spouses?

38. What should be done to improve male participation in PNC services?
39. In which area are men more involved between ANC services and PNC services, and why?
40. Where do you have a favourable response of male involvement in health services between rural and urban settings?
41. Do you have adequate supplies, equipment, and staff for ANC/PNC services?
42. What challenges does your centre faces concerning male involvement in ANC/PNC services?
43. Generally what are the attitudes of community, men, women, traditional leaders and community leaders on male involvement in ANC/PNC services?
44. What factors affect male involvement in ANC/PNC services?

APPENDIX THREE: FOCUS GROUP DISCUSSION

FOCUSED GROUP DISCUSSION (FGD)

SECTION A

KNOWLEDGE ABOUT MALE INVOLVEMENT IN ANC SERVICES

- What do you understand of ANC?
- Are you aware of ANC services in your area?
- What are the sources of information about ANC /PNC {Peers, TV, Radio, Church meetings}
- What was the last source of information about ANC?
- How often do you attend the ANC services?
- When did you last hear about ANC?
- Do you go with your spouse to ANC service?
- How often do you go with your spouse to ANC service?
- During ANC visit what information do you get?
- Are men involved in ANC service in your community?
- What aspects of ANC services do men follow?
- Do you know anything about PNC service?
- What do you know about PNC services?
- How did you get to know about PNC services?
- What PNC services are available in your community?
- In the past five years, have you/your spouse given birth?
- Did you visit PNC services?
- Who advised you to go for PNC service?
- Have you/your spouse ever accompanied you for PNC services?
- Under what circumstances did you/your spouse accompany you?
- Are men fully involved in PNC services?
- What aspects of PNC resources are involved?
- What is learned at ANC beneficial for your health?

SECTION B

ATTITUDES OF MALE INVOLVEMENT IN PNC SERVICES

- Have men in the past five years changed their attitudes towards their wives when they are pregnant.
- What is causing the change of attitude?
- In which ways have they changed?
- What really are your feelings on the following;

- v Women issue
- v Health workers not accommodating
- v Community not supportive
- v Economic issues
- v Cultural issues
- v Religious issues

Ø Elaborate for each of the above how they affect male involvement in ANC/PNC services in this community.

- When you last went for ANC/PNC services were you welcome?
- If you/your spouse got pregnant, would you be willing to visit ANC/PNC health services?
- Do men value the ANC/PNC services in your community?
- What are men's general feelings towards ANC/PNC services in this community?
- What should be done to improve male involvement in ANC/PNC services?

SECTION C.

PRACTICE: LEVELS OF MALE INVOLVEMENT IN ANC/PNC.

- Are you involved in ANC/PNC services?
- How are you involved?
- In the past five years have you/your spouse been pregnant or breast feeding?
- When you/your spouse had a child, did you/your spouse visit ANC services?
- Which services were you pursuing?
- What was your role?
- Do you always attend ANC/PNC services with your spouse?
- If you do how often?
- If you don't why?
- Out of 10 women who go for ANC/PNC services how many do you think would be accompanied by their spouses?
- Do you practice what you learn during ANC/PNC services?
- Do health workers make follow-ups to the spouses after ANC/PNC services?
- Do you/your spouse give assistance during ANC/PNC services?
- Do men feel comfortable to accompany their spouses during ANC/PNC services?
- For what services do men accompany their spouses?

SECTION D

FACTORS AFFECTING MALE INVOLVEMENT IN ANC/PNC SERVICES

- What challenges do men face when they accompany their spouses for ANC/PNC?
- How far are the ANC/PNC services from your community
- What mode of transport do you use for ANC/PNC?
- When you/your spouse visited ANC centers did you/your spouse face challenges?
- What challenges did you/your spouse face?
- In which area do you feel men are more involved between ANC and PNC? And why?
- What factors are affecting provision of ANC/PNC services (economic, cultural etc.)
- How are the factors affecting male involvement in ANC/PNC services?
- What roles should the following do to enhance male participation in provision of and use of ANC and PNC services?
 - 1) Religious leaders
 - 2) Community leaders. (e.g NHC, CHW, chairpersons).
 - 3) Traditional leaders. (e.g chiefs, headmen).
 - 4) Civic leaders e.g Mps, Counselors.

What should be done to improve male involvement in ANC/PNC services in this community?