PERCEPTIONS AND EXPERIENCES OF YOUNG PREGNANT WOMEN AGED 15 – 19 YEARS ON MALE INVOLVEMENT AT ANTENATAL CARE CLINICS OF MWENSE DISTRICT, LUAPULA, ZAMBIA.

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Bachelor of Adult Education (BAE)

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DECLARATION

I hereby declare that all the work in this dissertation is my own and has never been submitted for another degree in this or any other University or Institution of higher learning.

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DEDICATION

To God who is my strength

To my wife Annie Chibesa Kapenda, my siblings Grace Kapenda Mwape and Wilson Kapenda Mwape (Jr). To my mother Dora Mwila Mwape and lastly I dedicate this dissertation to the living memory of my late father Wilson Mutambala Mwape.

ABSTRACT

Male involvement in antenatal care clinic is defined as the male partners' active participation in attending antenatal services. Men serve as gatekeepers to women's access to reproductive health services. Male participation in antenatal care and HIV testing helps to decrease infant HIV infection and increases HIV free survival in children. However, male involvement has been low in Zambia, especially among partners of young pregnant women. The study aim was to determine the perceptions and experiences of young pregnant women on male involvement at antenatal care clinics and to assess their acceptability of male involvement at ANC.

The study was conducted in Mwense District of Luapula province. Phenomenological design and purposive sampling were used. Three focus group discussions and thirty in-depth interviews were conducted. Thematic analysis was used. Analysis of data was done manually. Themes were deductively coded from the interview guides, theoretic framework and objectives of the study. Other themes were processed inductively from the data transcriptions. Triangulation involved assessing the data for consistency and potential variations of findings.

Generally, young pregnant women perceived male involvement at antenatal care clinics as a good programme. Male involvement was highly acceptable but with low utilization. It was perceived to help couples prepare for delivery, increase love and care, and learn more about HIV. Male involvement was considered helpful for a healthy pregnancy and safe delivery. The participants felt the need for programme continuity. Male-friendly antenatal care services should be developed. The young women's experiences of male involvement were mixed, ranging from a better and quick service if accompanied, to being scolded and delay in being attended to if they were not accompanied by a partner.

Male involvement left young pregnant women with both negative and positive experiences. The negative experiences made them to have bad perceptions while positive experiences helped the young pregnant women appreciate the programme as being to their benefit hence the desire to have it continue. Community-based programs that would promote male involvement and minimise associated stigma need to be initiated. Male targeted programmes that encourage men to attend antenatal care clinics should be considered. Future studies on views of men with young pregnant partners and their perception on male involvement are recommended. This would aid formulation of targeted interventions for the programme.

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CONTENTS

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal Care
ARV	Antiretroviral
DMO	District Medical Office
EMTCT	Elimination of mother-to-child transmission
FGD	Focus Group Discussion
FHI	Family Health International
HIV	Human immunodeficiency virus
IDI	In-Depth Interview
MCH	Maternal and Child Health
MI	Male Involvement
MoH	Ministry of Health
MTCT	Mother-to-child transmission
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission (of HIV)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
UNZABREC	University of Zambia Biomedical Research Ethics Committee
USAID	United State Agency for International Development
VCT	Voluntary counselling and testing

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CHAPTER ONE

INTRODUCTION

The reproductive health of women is hugely dependent on the involvement of their male partners. Men serve as gatekeepers to women's access to reproductive health services. Male involvement (MI) is an important recommendation for the Prevention of Mother-to-Child Transmission (PMTCT) of Human Immunodeficiency Virus (HIV) programme as their participation in antenatal care (ANC) and HIV testing has been found to decrease infant HIV infection and increase HIV free survival (Nyondo et al., 2014). There are many activities at ANC clinic but men are mainly involved in PMTCT. MI is not just about promoting men to accompany their partners to antenatal clinic, but for men to provide supportive roles in their families, and also to bring men into HIV preventive and care services. MI in PMTCT is defined as the male partners' active involvement in attending antenatal care services and HIV testing during the antenatal period as well as the couple's acceptance of PMTCT if the mother is found to be HIV positive (Haile and Brhan, 2014).

Men are traditionally not directly involved in their partner's health in many sub-Saharan countries, although they most often make decisions about use of services. Men may provide financial support but attending health services with their partner is not seen as part of the male's role. There are therefore huge challenges in efforts to get men involved in reproductive health services and there is a need to better understand how to promote male involvement in different settings. Antenatal care services need to be more "male-friendly" to encourage more men to attend with their spouses (Jones, 2014). Teenage pregnancy refers to pregnancy of a woman of less than 19 years (Mothiba and Maputle, 2012). A teenager is an individual in the transitional stage of development between childhood and full adulthood, representing the period of time during which a person is biologically adult but emotionally not fully matured (Matthews, 2007). In this study, a teenager is a female person aged between 15–19 years. Pregnancy is the state in which a foetus develops in the uterus of a woman, during the period from conception to birth (Darmstadt et al., 2014).

Benkele (2012) contend that the HIV/AIDS epidemic has not only resulted in high morbidity and mortality among Zambians, but it continues to pose a great challenge on the Zambian economy.

Zambia has one of the highest HIV prevalence rates in the world, with an adult HIV prevalence rate of 12.5% (11.9% in men and 13.3% in women) (WHO, 2013). Approximately one out of ten new infections occur in children aged 0 to 14, the majority of which are due to vertical transmission. Among pregnant women, HIV prevalence remains high at 13.3%. There were 2,946 new HIV infections among children aged 1 to 4 in 2011. Only 28.2 of children aged 0-14 years have been put on antiretroviral therapy compared to 90.0% among adults 15 years and older (Say et al., 2014). Due to funding from the President's Emergency Fund for AIDS Relief (PEPAR) of the United States government, there was a dramatic increase in PMTCT service coverage between 2008 and 2011. PMTCT services are now offered at nearly every service delivery point for ANC in the country (MoH, 2009).

Some 11% of all births worldwide are to girls aged 15 to 19 years, and the vast majority are in low- and middle-income countries (WHO, 2011). The 2014 World Health Statistics put the global adolescent birth rate at 49 per 1000 girls. This age, country rates range from 1 to 229 births per 1000 girls. This indicates a marked decrease since 1990. This decrease is reflected in a similar decline in maternal mortality rates among 15-19 year olds. Adolescents in Sub-Saharan Africa are concerned about preventing both HIV and unplanned pregnancy and for good reason. Young people in Africa are much more likely to be living with HIV than adolescents in other regions around the world (WHO, 2013). Across Sub-Saharan Africa, HIV is spreading throughout the general population. Young women are more greatly affected than young men: An estimated 4.3% of women aged 15–24 in Sub-Saharan Africa are living with HIV, compared with 1.5% of men in that age-group (Unterscheider et al., 2014).

In some countries, the rates are much higher; 15% or more of young women in Botswana, South Africa, Swaziland and Zimbabwe are living with HIV (Orne-Gliemann et al., 2010). While women in Sub-Saharan Africa are now less likely to be married in their teenage years than they were in the past, a substantial proportion of women still marry at a young age (Mothiba and Maputle, 2012). Although rates vary considerably from country to country, roughly four in 10 women in Sub-Saharan Africa marry before turning 18 and six in 10 women do so by age 20. In contrast, slightly more than one in 10 men in Sub-Saharan Africa marry before turning 20. Zambia is home to over 800,000 Orphans and Vulnerable Children (OVC) 0-17 years of age due to AIDS. Four in ten children under age 18 are not living with both parents; and 15 percent of children under age 18 are orphaned, one or both parents are dead (Central Statistical Office

(CSO) [Zambia], 2014). This situation makes it imperative to consider the importance of male involvement at antenatal clinic in this vulnerable age group.

Comprehensive knowledge about Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) is lowest among young women and men age 15-17 (35 percent and 40 percent, respectively) and Mother-To-Child Transmission (MTCT) knowledge is lowest among the youngest respondents (age 15-19) (62 percent of women and 44 percent of men) (Central Statistical Office (CSO) [Zambia], 2014). It also shows that 80 percent of women age 15-49 have been tested for HIV. Only 2 percent of women who had been tested for HIV did not receive the test results. The percentage of women who have been tested for HIV is lowest among those aged 15-19 (49 percent), those who have never been married and never had sex (32 percent), those with no education (77 percent), and those in the lowest wealth quintile (77 percent). In view of these findings, male involvement could be among the reasons why young women continue to be the lowest.

Adolescents may lack knowledge of access to conventional methods of preventing pregnancy, as they may be afraid to seek such information. In a Limpopo Province study by Mothiba and Maputle (2012), the findings were classified as demographic data where 24% of the respondents were aged between 15–16 years and 76% were aged between 17–19 years. Findings further revealed that 60% of the respondents started to engage in sex at 13–15 years; 48% of the teenagers' partners were 21 years and above, 44% depended on a single parents' income; 20% father's income, 16% received a social grant and 8% lived on the pension fund of the grandparents. Hence, this study is necessary as it is looking at a vulnerable group in which there are few studies that have been conducted.

1.1.Statement of the problem

Orne-Gliemann (2010) concedes that studies generally support male involvement to promote PMTCT, but the nature and impact of that involvement is unclear and untested. Additionally, stigma, disclosure and intimate partner violence pose significant barriers to PMTCT uptake and retention in care, suggesting that male involvement may be 'necessary, but not sufficient' to reduce infant HIV incidence (Jones, 2014). Men possess general HIV knowledge but lack specific information regarding PMTCT and may feel unable to attend ANCs due to work schedules. Men also may regard ANC health facilities as being 'generally unfriendly' to them (Letshwenyo-Maruatona, 2012). Men are perceived as decision-makers in the home, and feel

their position is undermined if they are expected to attend a 'women's clinic program', leading them to decline to attend ANC visits with their partners.

Young pregnant women encounter a lot of challenges due to lack of support from their male partners. Stillbirths and death in the first week of life are 50% higher among babies born to mothers younger than 20 years than among babies born to mothers 20–29 years old (Cousens et al., 2011). Deaths during the first month of life are 50–100% more frequent if the mother is an adolescent versus older, and the younger the mother, the higher the risk. Complications linked to pregnancy and childbirth are the second cause of death for 15-19-year-old girls globally (Mothiba and Maputle, 2012). The rates of preterm birth, low birth weight and asphyxia are higher among the children of adolescents, all of which increase the chance of death and of future health problems for the baby. It is found commonly amongst young people who have been disadvantaged and have poor expectations with regard to either their education or job market. Therefore, young pregnant women who are vulnerable can benefit from the involvement of men in antenatal care clinic.

Table 1.1: Mwense District ANC attendance by gender January, 2012 to March, 2013.

Months	Antenatal total visits (calc)	Antenatal male client	Male partner (%)	Antenatal female client	Female partner (%)
January, 2012	1,612	447	28	1165	72
February	1,462	373	25	1089	75
March	1,547	442	29	1105	71
April	1,853	382	21	1471	79
May	1,730	549	32	1181	68
June	1,347	347	26	1000	74
July	1,845	434	24	1411	76
August	1,532	381	25	1151	75
September	1,478	326	22	1152	78
October	972	445	46	527	54
November	1,086	378	35	708	65
December	939	276	29	663	71
January, 2013	1,128	415	37	713	63
February	936	324	35	612	65
March	847	348	41	499	59

Sources: Mwense District HIA 2 Data set

Mwense District has had low attendances of males at antenatal care clinic. The only challenge is that data is not separated according to the required age group of 15-19 years. However, the general picture as reflected by the 2012-2013 health information aggregation data shows an approximate disparity of about one-third between male and female antenatal care attendance as illustrated above. Health workers provide health education in Zambia but low utilization of PMTCT services by males continue. Most studies on male involvement in Zambia focus on HIV/AIDS. There Limited published studies on male involvement focusing on young pregnant women.

1.2. Justification

Male involvement provided an opportunity to couples' testing and counselling (Clark, 2012). Disclosure to partner did not yield violence, a man cared for his partner if she tested positive. He supported and encouraged adherence to antiretroviral treatment (ART). The initiative of MI contributed to the attainment of the WHO global targets on reduction of new infections among children, reduction in maternal deaths, and in under-five deaths due to HIV. It is indicated by UNAIDS, 2011 that if interventions are scaled up and Global Plan targets achieved, new child infections would reduce to 4, 400, an 81% decline in the number of new child infections from 2009. Making men meaningfully and adequately involved in antenatal care services can contribute significantly to the elimination of new HIV infections (Nguni, 2013).

The findings of this study are of great benefit to the health workers, young pregnant women and the entire community. This study adds to the body of knowledge on male involvement of partners of young pregnant women aged 15-19 years at antenatal clinic. The findings could contribute to the efforts towards Elimination of Mother-To-Child Transmission (EMTCT) of HIV.

Studies have shown that lack of male partner involvement is one of the major factors that are responsible for poor uptake of PMTCT services. There were no studies that are focusing on the selected age group. The studies reviewed have not considered the age group which has been a gap in knowledge that this study could address. Most studies have considered male involvement on a general perspective without paying particular attention to the marginalized group as captured in this study. The success of this study could bridge this existing gap.

1.3.Study question

What are the perceptions and experiences of young pregnant women aged 15–19 years on male involvement at antenatal care clinic?

1.4.General objective

The general objective was to assess the perceptions and experiences of young pregnant women aged 15–19 years on male involvement at antenatal care clinic in Mwense District.

1.4.1. Specific objectives

i. To determine the perceptions of young pregnant women aged 15-19 years on male involvement at ANC.

ii. To investigate the experiences of young pregnant women aged 15-19 years on male involvement at ANC.

iii. To assess the acceptability of male involvement at ANC among young pregnant women aged 15-19 years.

CHAPTER TWO

LITERATURE REVIEW

MI in the PMTCT of HIV services is essential in a patriarchal society where men are decision makers of the household (Sherr and Croome, 2012). Male partners have a role to play in the woman's risk of acquiring HIV, uptake of HIV testing and participation in MTCT prevention programmes. Although MI is important for uptake of PMTCT interventions, it remains low in Africa (Nyondo et al., 2014). A precise and universally accepted definition of male involvement in PMTCT is lacking. The definition of the term "male involvement" varies according to authors. Some authors define male involvement as male partners' participation in HIV testing solely during ANC (Byamugisha et al., 2010b). Others consider male participation in HIV couple counseling as male involvement (Ditekemena, 2012). The majority of studies defined male participation as male involvement solely during antenatal HIV testing.

2.1. Limiting factors for male involvement.

In a Ugandan study by Byamugisha et al. (2011), 34 studies were included in the review, which reported on male participation in Maternal and Child Health (MCH) and PMTCT services. Three main determinants for male participation in PMTCT services were identified which include: Socio-demographic factors such as level of education, income status; health services related factors such as opening hours of services, behaviour of health providers and the lack of space to accommodate male partners; and sociologic factors such as beliefs, attitudes and communication between men and women. Male participation is a crucial component in the optimization of MCH services. This is especially so where prevention strategies to decrease MTCT of HIV are sought (Nguni, 2013). It is clear however that improvement of antenatal care services by making them more male friendly, and health education campaigns to change beliefs and attitudes of men are absolutely needed (Ditekemena, 2012).

Byamugisha et al. (2010) reported that harsh, critical language directed at Ugandan women from skilled health professionals was a barrier to male participation. Harsh treatment of men by health providers discouraged them from returning or participating in PMTCT activities. Furthermore, some providers did not allow men access to ANC settings. This study further reported that some health providers charged extra beyond the official ANC fees to bridge their own financial gaps

while other authors have identified low health providers' salaries as limiting factors for male involvement.

2.2. Assessing suitable venue for male involvement in ANC.

In the study in the Democratic Republic of Congo (DRC), men were invited for voluntary counseling and testing (VCT) in three venues: a bar, a health center and a church. Male involvement in VCT was higher in the bar (26, 4%, $p < 0,001$) and church (20,8%, $p = 0,163$) compared with the health center (18,2%) (Ditekemena, 2012). These results suggested that more friendly and convenient venues for men are needed. The lack of space to accommodate male partners in ANC clinics was also reported to adversely impact male involvement Byamugisha et al., (2010). Clinics are often unable to concurrently accommodate pregnant women and their partners because of a lack of space. Gender specific services to address uniquely male issues do not exist. Targeted interventions for men, such as tailored messages, specific health education sessions, and innovative strategies to identify male friendly venues would be valuable for increasing male involvement (Duff et al., 2012). Frequently women have to wait for a long time before receiving ANC services because of burdensome administrative procedures which result in poor patient/client through-put in health facilities. Men, who frequently are in the paid workforce, are often not in a position to spend virtually the entire day participating in ANC services (Ramirez-Ferrero and Lusti-Narasimhan, 2012). Health service providers are often overworked, stressed, and have to work in an infrastructure with severely limited resources. In such context, the quality of services is compromised and taking care of participating male partners is considered an additional burden (Adelekan et al., 2014).

2.3. Levels at which barriers of male involvement in ANC exist.

Morfaw, et al. (2013) identified 24 studies from peer-reviewed journals; 21 from sub-Saharan Africa, 2 from Asia and 1 from Europe. Barriers to male involvement in PMTCT were mainly at the level of the society, the health system and the individual. The most pertinent was the societal perception of antenatal care and PMTCT as a woman's activity, and it was unacceptable for men to be involved. Health system factors such as long waiting times at the antenatal care clinic and the male unfriendliness of PMTCT services were also identified. The lack of communication within the couple, the reluctance of men to learn their HIV status, the misconception by men that their spouse's HIV status was a proxy of theirs, and the unwillingness of women to get their

partners involved due to fear of domestic violence, stigmatization or divorce were among the individual factors. Actions shown to facilitate male involvement in PMTCT were either health system actions or factors directly tied to the individuals (Pfizer, 2012). Inviting men to the hospital for voluntary counseling and HIV testing and offering of PMTCT services to men at sites other than antenatal care were key health system facilitators. Prior knowledge of HIV and prior male HIV testing facilitated their involvement. Financial dependence of women was key to facilitating spousal involvement.

Most health facilities offer these services only on weekday mornings, when the majority of men are at work. Yet several studies have identified ANC opening hours as a limiting factor for male involvement (Morfaw et al., 2013). Permanent PMTCT services would facilitate the services' uptake even for men with difficult work schedules. Geographical constraints impact health services uptake and male participation (Ditekemena, 2012). Lack of decentralized services is a reason for low health services uptake and limited male involvement. A qualitative study conducted in western Kenya by Reece et al. found that the distance that the male partners have to travel to the clinics for participating in the education, HIV tests and counseling, the costs of the transport to the clinics and the amount of time per appointment at the clinic were identified as barriers to male involvement (Reece et al., 2010). Data from another study from Uganda showed that majority of participants said that the health facilities were few and located far from the people, making the health services such as HIV testing and counseling inaccessible. Most of the male partners and men in general wanted the health services to be implemented and extended to their villages or close to their homes in order to save them the costs of time and travel fee (Morfaw et al., 2013).

Several studies have reported negative perceptions towards men attending ANC services. In one report, men who accompanied their wives to ANC services were perceived as being dominated by their wives (Jennings et al., 2014). Frequently men perceive that ANCs services are designed and reserved for women, thus are embarrassed to find themselves in such "female" places (Byamugisha et al., 2011). Certain women too, do not like to be seen with their male partner attending the ANC service. A study conducted in Kenya showed that certain male clients trust traditional healers but not hospitals and therefore do not attend ANC clinics (Reece et al., 2010). In many studies men were mentioned being concerned about HIV-associated stigma and disclosure (Benkele, 2012). Men may be afraid of HIV status disclosure in a health system

facility, in the context of weak health system. Poor communication between men and their female partners was associated with poor male involvement. On the other hand, good couple communication was associated with high HIV status disclosure and support between husband and wife.

Several studies showed that women at ANC clinics fear violence from their partners who attend ANC clinics with them. These women fear that discovery of a positive HIV test result may lead to abandonment, rejection or being perceived by their husband as being responsible for bringing HIV into the couples' relationship (Ditekemena, 2012). Gender-based violence is another cause of low male involvement. Victims of gender-based violence may be afraid to ask their partner to be tested for HIV. Reinforcement of women's power for negotiation would be a major asset.

2.4. Men's willingness to participate in antenatal care and EMTCT

In a study conducted by Abiodun in April, 2014 in Quthing District, what came out clearly is that women viewed antenatal care as important to having good pregnancy result and they see it as an avenue to get tested. Majority of the women (68%) were in support of their partners' involvement in antenatal care. The staff of MCH were in total support of this. Cultural factors and gender based beliefs were found to be hindering male involvement in EMTCT programme and getting tested for HIV. The results also show that the staff of MCH have positive attitudes towards people living with HIV (Abiodun, 2014).

The remoteness of available care also increases the vulnerability of young pregnant women and their unborn children to HIV (Hardon et al., 2012). In this strongly patriarchal society, the average woman bears more than six children. Although there is still much more work to be done in Zambia, the presence of widespread testing and treatment services has had a great impact. Despite many efforts by the Zambian government to implement effective EMTCT programmes, there remain many challenges on both the demand- and supply-side. A report by the South African Development Community (SADC) highlighted that many policies on EMTCT in Zambia have been developed and adopted from global policies, but that policy and practice are not always aligned, due to socio-economic and socio-cultural factors at play (UNAIDS, 2011).

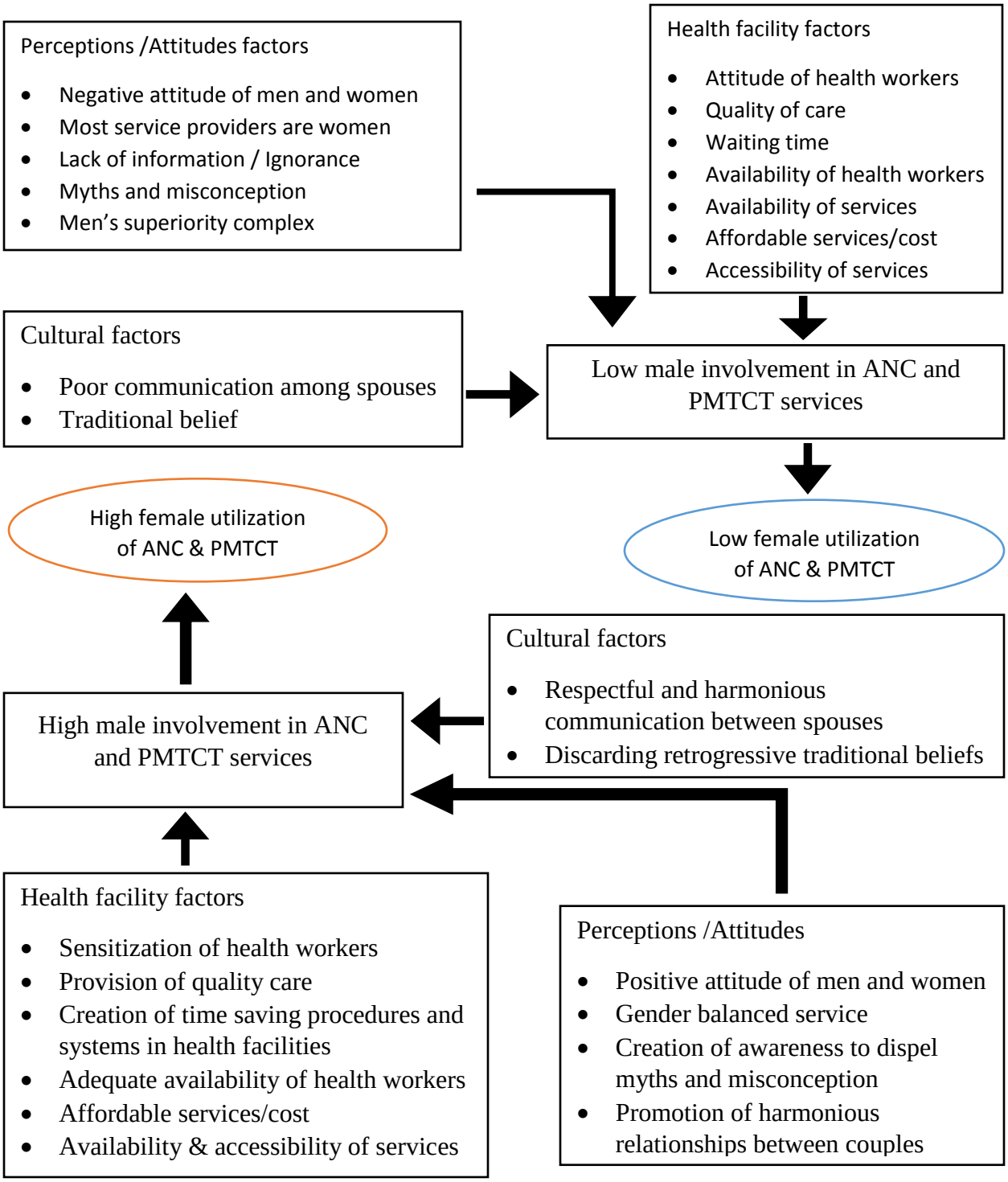
The spread of HIV is further compounded by other structural factors that are underpinned by social and cultural norms, and limitations in service delivery. Among them are stigma and discrimination, gender inequalities, low levels of education, and rural-urban dichotomy in

accessing services (Rosen., 2010). It is critical to understand these determinants in order to establish why EMTCT retention of clients is low in Zambia. There are limited data on strategies for MI in PMTCT. They include a gatekeeping strategy with two subcategories: healthcare workers refusing service provision to women accessing antenatal clinic without their partners and women refusing ANC attention in the absence of a partner.

Background descriptive studies painted a picture of low male involvement, poor male inclusion and barriers to engagement at all stages (Falnes et al., 2011). Yet, pregnancy intentions among men affected by HIV are high and the importance of fathers to family functioning, from relationships, through conception, pregnancy and parenting is well established. Search strategies for interventions for males in HIV and pregnancy were used to generate studies of sufficient quality to inform strategies on the future of male involvement. Of the 317,434 papers on pregnancy and HIV, only 4178 included the term male or paternal or father (Sherr and Croome, 2012). When these were restricted to intervention studies, only 248 remained for hand sorting, generating 13 studies of relevance for data extraction. The results show that all these interventions were concentrated around male partner HIV testing.

In general, male partner testing was low and was amenable to change by offering VCT information, providing couple-based testing facilities and encouraging male attendance (Sherr and Croome, 2012). All interventions used indirect approaches to men via their pregnant spouse. Non-health facility or clinic or hospital-based provision such as testing facilities in the community in bars and churches were more effective than healthcare facilities in attracting male participation The studies suggest that men are willing to engage, yet often feel marginalized or of secondary importance (Auvinen et al., 2013). Indeed, almost all of the interventions did not directly approach men and used women as a proxy to invite or take messages to their partners for attendance and inclusion. The UN aim of virtual elimination of HIV infection to end infection in newborns is an achievable goal (UNAIDS, 2011).

Figure 2.1: Theoretical framework of factors affecting male involvement in ANC and PMTCT



Adopted from Ongweny-Kidero (2014)

Ongweny-Kidero (2014) concede that the factors that affect male involvement in ANC and PMTCT services may be categorized into cultural factors, socio-economic, health facility factors, inter-spouse communications, and perceptions men have on these services in the community. Cultural factors include traditional beliefs which endear some couples to trust traditional medicine compared to modern medicine and poor communication among couples which stems from traditional beliefs that men are the heads of the households, their word is law and cannot be questioned. Health facility factors include lack of privacy and confidentiality, comfort and poor attitude of health workers, adversely affect men's capacity to be involved in ANC and PMTCT services (Ongweny-Kidero, 2014).

Perceptions men have on these services range from ignorance, lack of information, myths and misconceptions and men's superiority complex. The time taken in the health facilities is also a deterrent for most men because they compare this with time taken away from income generating activities. Low male involvement in ANC and PMTCT will lead to low utilization of these services by expectant women and their infants, which will lead to high maternal and infant morbidity/mortality (Villar-Loubet et al., 2013).

CHAPTER THREE

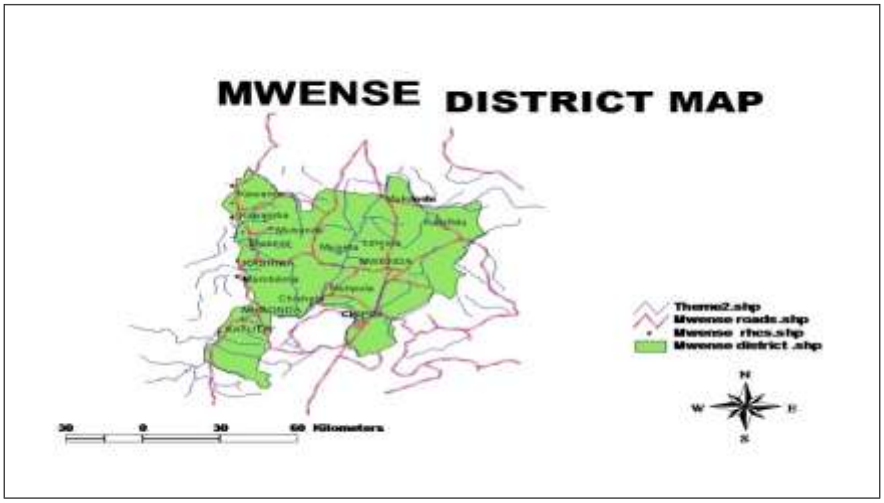
METHODOLOGY

3.1. Study area

The study was conducted in Mwense district of Luapula province. There is no district hospital in Mwense. The district only has health centres and health posts which provide primary health care services including preventive, curative, promotive and rehabilitative health services. The district procures other first level hospital services from Mansa General Hospital and Mbereshi Mission Hospital in Mwansabombwe. The settlement pattern of the people of Mwense is that of villages in all the catchment areas of the Health Facilities. Majority of employees in Mwense are those employed by the government in the following sectors; education, health, agriculture, judiciary and the local council. Other forms of employment are a few shops as well as peasant fishing. The literacy level in the district is at 40% with more males being literate compared to females. The absence of factories and industries has increased unemployment levels in the District. Most of the Health Facilities in Mwense District are along the main road and only a few are located some distance from the main road.

There were nine Facilities which were selected in this study and these included Katuta RHC, Chibondo RHC, Kashiba RHC, Mwense RHC, Lubunda RHC, Musangu RHC, Lukwesa RHC and Mununshi RHC. All these health facilities are located along the road side thus they were conveniently sampled.

Figure 3.1: Mwense district map



3.2. Study design

A qualitative phenomenological approach was used to examine the views and experiences of young pregnant women. The study took a phenomenological approach, as it is 'the participants' perceptions, feelings, and lived experiences that are paramount and that were the objective of the study' (Guest et al., 2012). Phenomenological research focuses on people's daily life experiences. It is a meaning-oriented 'approach and includes discovering, analysing, clarifying and seeking patterns of a certain phenomenon, based on a description of how the life of humans is through the researchers' complementary insights into the data collection process as well as the collected data (Creswell, 2012).

3.3. Study population

The study population consisted of young pregnant women aged 15-19 years attending antenatal care clinic. Two participants were selected from each Facility of the selected six Facilities in the District.

Table 3.1. Socio-demographic characteristics of the study population

S/No	Variable		Frequency	Percentage
Total			30	100
1.	Age	15	1	3
		16	3	10
		17	4	13
		18	8	27
		19	14	47
2.	Marital status	Married	16	53
		Not married	14	47
3.	Marital year	2013	1	6
		2014	6	38
		2015	9	56
4	Number of children	No child	27	90
		One child	3	10
5	Education level	Never being to school	1	3
		Lower primary school	2	7
		Upper primary school	12	40
		Junior secondary school	14	47
		Senior secondary school	1	3
6.	Occupation	Farming	22	73
		Business	3	10
		Doing nothing	3	10
		Fishing and piece works	1	3
		Farming and business	1	3
7.	Guardian	Husband	15	50
		Parents	9	30
		Mother	5	17
		Sister	1	3

3.4. Sampling criteria and sample size

The study area was selected for its poor performance in male involvement. Seven out of the twelve health facilities were conveniently selected for the study due to their location. Convenient sampling was used to come up with the sample from the population which was readily available and accessible. When selecting participants for the study, the assistance of nurses or other health care providers was sought. The sample size included thirty young pregnant women aged 15-19 years for in-depth interviews (IDI), which had sixteen married women and fourteen unmarried women. It also included three focus group discussions (FGD) that included maximum of ten young pregnant women aged 15-19 years per group from three health facilities. The three health

facilities where the focus group discussions were held were randomly selected from the remaining facilities that were not picked for in-depth interviews. The location of the three facilities is as follows; one from the lower valley, central valley and one from the upper valley. FDGs were meant to help in the triangulation of data.

3.5. Data collection

Data was collected by the principle researcher with the help of seven (7) research assistants who were trained before going for data collection. The interviews followed an IDI guide. To complement insights from the interviews, three FGDs comprising 6–13 individuals were conducted with different pregnant women of the same age identified from the antenatal clinic in the health facilities of the District to capture their perceptions. Participants in the FGDs were conveniently sampled. The IDIs participants were purposely selected according to their age and pregnancy. A semi-structured IDI guide and a FGD interview guide were used to collect detailed information from participants using the local language commonly spoken in the area. The interview guides were formulated in English and translated into Bemba. Back translation was done into English to check for consistency by a trained teacher. A tape recorder was used in both IDIs and FGDs. A total of thirty IDIs were conducted with young pregnant women aged 15-19 years. All participants attended only one individual interview, which lasted for 30-45 minutes. Open-ended questions and inductive probing were adopted during the data collection process. This allowed us to clarify expressions or meanings of the young pregnant women's daily experiences at home and communities, and further permitted them to freely tell their stories. In addition, observations of non-verbal cues were done by the researcher.

3.7. Data Management and analysis

All interviews were recorded digitally and later transcribed verbatim. Analysis was manually done and started while in the field. Thematic framework analysis, which involved identification of common themes and issues, was used to analyse data. Thematic framework analysis was used because it is good for research or programmes that are being rolled out, as it is less theoretical (Huberman and Mile, 2002).

The first stage was familiarisation. This was the processes of gaining an overview of the collected data. It involved immersion in the data through reading and re-reading of transcripts.

After familiarisation, came the generation of codes. A code is a word, phrase or sentence that represents aspects of a data or captures the essence or features of the data (Saldana, 2013). The coding process involved matching of codes with segments of text/informant statements selected as representative of the code (Ritchia, 2003). During the coding process, substantial emphasis was placed on returning the original meaning of what was communicated by the informants.

The next level involved searching for themes among codes. The first step in this level was categorization. This involved grouping the coded segments into 'Subthemes' based on similarity of content. This was done in order to reduce the number of different pieces of data in the analysis. In this light, similar codes were grouped together to form categories.

The categories of content were evaluated to assess if generalisations could be made. Thus, major themes were developed by interpreting the categories for their underline meaning. Themes in this case were the higher level of categorization that was used to identify the major elements while the entire analysis of the data. A theme can thus be said to be an outcome of coding, categorization and analytic reflection (Saldana, 2013).

By using this analytical strategy, participant's perceptions were explored as well as the broader social environmental context that may influence them. A summary of the relevant concepts is shown below:

Table 3.2. Factors and themes

Major factors	**Themes**
Perceptions of male involvement	Negative attitude of men and women
	Most service providers are women
	Lack of information / ignorance
	Myths and misconception
	Men's superiority complex
Health facility dimensions	Attitude of health workers
	Quality of care
	Waiting time
	Availability of health workers
	Availability of services
	Affordable services/cost
	Accessibility of services
Cultural values and practice	Poor communication among spouses
	Traditional belief

Although, the analysis is presented like a linear process, it should be emphasised that it involved a continuous shifting back and forth between the different data sets as well as between the participants' narratives and the researchers' interpretation of the meanings of the material (Chapman, 2002).

3.8. Disposal plan

After all the collected data had been analysed, thesis development completed and findings published in a journal, the researcher would allow a time frame of three months to elapse after which all the questionnaires and tape recordings used for data collection would be disposed of.

3.9. Ethical consideration, ethical review and approval.

In regard to ethical consideration, since the study involved human beings, it was paramount to obtain consent to undertake this study from designated research and ethics committee and to the participants who were assigned. In view of this, the researcher got the approval from Excellence Research Ethics (ERES) (I.R.B. No. 00005948; E.W.A. No.00011697, reference number, 2015-June-014) (Appendix V and letter of approval attached). Permission was sought from Mwense District Medical Office to conduct the research from their health facilities. The investigator ensured that the well-being of each individual participant took precedence over all other interests. Respect for persons, beneficence, and justice were highly considered. This was achieved by the use of well elaborate information sheets and consent forms that were translated in the main common language spoken in Mwense (Bemba) to ensure that participants understood the decisions they were making and that, they participate with full consent.

The researcher explained to the participants about the importance of the study towards improving the quality of health delivery and to their wellbeing as young pregnant women before they accepted to participate in the study. They were told of their rights to decline or withdraw their participation any time if they so wished. Assurance was given to the participants that all information that would be given would be treated with utmost confidentiality. This anonymity was guaranteed by virtue of the respondents not disclosing their names and where they came from in terms of their village. Above all, the interviews were also carried out in exclusive places to ensure confidentiality and to have freedom of expression.

Eligible participants were given an information sheet, available in both Bemba and English, explaining the purpose and nature of the study and containing contact details of the researcher,

and after ascertaining that the information was clearly understood, eligible participants were invited to participate in the study. It was made clear that participation was voluntary and that the study was not being conducted by the antenatal service staff, and thus that the decision of whether or not to participate in the study was not going to impact on the women's antenatal treatment in any way. After it was explained that participation was voluntary and that participants were free to withdraw from the study at any time, participants were given to sign an informed consent or assent form either in Bemba and English.

Further permission letters were sought and signed by the parents/guardians/husbands to permit their children to participate in the study. Consent forms were then availed to those that were 18yrs old and above, while those below the age of 18 were availed with assent forms for their voluntary participation. The researcher is aware that the legal age of marriage in Zambia was 18 years, thus the study was carefully handled to avoid legal implications which had potential to delay the research. The study ensured that information is secured for confidentiality purposes. This was achieved by having a password on the computer and that all the gathered information together with the tape recorder were kept in a lockable cabinet in one of the offices. The questionnaires did not have identifiers to safeguard the privacy of the participants. No names were used; however, the interview guide was serial numbered for the purpose of data entry.

3.9.1. Respect for persons and confidentiality

A written consent was given to key informants and the parents of the pupils concerned. Only the pupils whose parents/guardians gave consent were interviewed. In addition, assent was obtained from the concerned pupils. Both the consent and assent forms had an information sheet attached. In the case of pupils, consent and assent were sort a week or two prior to the interview. This was done to give them ample time to make an independent decision without pressure. Obtaining consent and assent was important in this study for the sake of treating the participants justly; respecting the participants' basic right to autonomy; as well as encouraging active participation of participants (Levy et al., 2003).

Permission to use the tape recorder was sought from the respondent. Participants were assured that all information they gave would be treated with outmost confidentiality and that they would remain anonymous. In this regard, it was ensured that minimal personal data was collected on the participants especially geographical description. In the analysis and writing of the thesis, no

names were used. To maintain privacy, all electronic data in the computer were stored on a pass word-protected computer with access only restricted to the researcher (MPH Student).

3.9.2. Beneficence

Respondents were assured that no harm would be done on them as there were no risks from this study, apart from the likelihood of sharing confidential or personal information by chance or filling uncomfortable talking about some topics. These risks were tackled by encouraging and assuring the participants that all information from the interview would be kept confidential and that they had the right to withdraw from the interview or not talk about things they were not comfortable with. Apart from being assured of confidentiality, they were also urged to be as free as possible as the research team included a female like them. The researcher also tried to be as friendly and open minded as possible. This helped to remove the social barriers that the participants might have anticipated. In terms of benefits, the participants were educated on the subject matter as they had little or no knowledge about male involvement at anti natal clinic. As such the interviewer, after finding this inadequacy, began each session by educating the participants on male involvement at ante natal care clinics to create a platform for the interview questions.

There were no direct benefits for the participants but rather, their participation contributed to scientific knowledge.

3.9.3. Justice

All respondents were availed with information on how they had been selected. This helped in reducing uncertainties and answering questions such as ‘why me and not her?’ which the respondents may have had. Respondents were given information regarding their rights to quit the study anytime and to submit their complaint to the authority and even to the researcher.

In the case of those that participated in the FGDs, the participants were selected fairly. There were a variety of women that represented the distinct realities of the more powerful and less powerful groups (Schenk and Schuëller, 2005).

Ethical clearance was sought from excellence in research ethics and science (EREs). Approval was also obtained from Mwense District Medical Office and Health Facilities.

3.10. Pre-test/Pilot study

The semi-structured questionnaires were pre-tested in non-participating facilities. Prior to commencing the study, two (2) research assistants were trained for two days to familiarize them with the interview guides. Day one (1) was dedicated to going through the interview guide and analysing each question in order to understand the context. Day two (2) was field work in which the researcher and the two data collectors went to Lubunda Community Rural Health Centre to administer the interview guides to the eligible target group. During the pre-test data collection, the research and research assistant administered two (2) in-depth interview guides each to the target group and only one focus group discussion was conducted by on research assistant while we took notes. The Researcher took time to listen to some of the interviews that were conducted so as to hear if the context of the questions was understood. After the pre-test data collection, findings were discussed with the Research Assistants and the identified gaps in the data collection tool were amended so as to make sure that all the salient issues are captured by the interview guides.

3.11. Dissemination plan.

The findings of the study are to be communicated to both Family Health International (FHI) 360 and the District Medical Office in a brief discussion meeting for their consideration. Further, the findings are also to be discussed with some participant to inform them on the outcome of the study as part of feedback to them. The findings are equally to be published in the international journal for public accessibility. In addition, copies of the thesis are to be shared to the University of Zambia Public Health library.

CHAPTER FOUR

RESEARCH FINDINGS

The study aimed to determine the perceptions and experiences of young pregnant women on male involvement at antenatal care clinics and to assess their acceptability of male involvement at ANC. Male involvement in antenatal care clinic is defined as the male partners' active participation in attending antenatal services. Men serve as gatekeepers to women's access to reproductive health services. Male participation in antenatal care and HIV testing helps decrease infant HIV infection and increases HIV free survival in children. However, male involvement has been low in Zambia, especially among partners of young pregnant women.

4.1. Socio-demographic characteristics of the respondents

Table 4.1. Socio-demographic characteristics of the respondents

S/No	Variable		Frequency	Percentage
Total			30	100
1.	Age	15	1	3
		16	3	10
		17	4	13
		18	8	27
		19	14	47
2.	Marital status	Married	16	53
		Not married	14	47
3.	Marital year	2013	1	6
		2014	6	38
		2015	9	56
4	Number of children	No child	27	90
		One child	3	10
5	Education level	Never being to school	1	3
		Lower primary school	2	7
		Upper primary school	12	40
		Junior secondary school	14	47
		Senior secondary school	1	3
6.	Occupation	Farming	22	73
		Business	3	10
		Doing nothing	3	10
		Fishing and piece works	1	3
		Farming and business	1	3
7.	Guardian	Husband	15	50
		Parents	9	30
		Mother	5	17
		Sister	1	3

Age: A total of 30 young pregnant women participated in the study. The age of the respondents was from 15 to 19 years old. Fourteen of the respondents were 19 years. The respondents who were 18 years were eight. One respondent was 15-year-old, three were 16 years and four were 17 years (Table 4.1).

Marital status: Married respondents were sixteen and unmarried respondents were fourteen (Table 4.1).

Number of children: Twenty-seven out of thirty respondents had no children (Table 4.1).

Education level: There was one respondent who has never being to school, two respondents attended lower primary school and twelve respondents attended upper primary school. fourteen respondents attended junior secondary school and only one respondent attended senior secondary school (Table 4.1).

Occupation: twenty-two respondents survived on farming, three respondents were doing business, one-tenth respondents had nothing to do, one respondent was engaged in fishing and piece works while another respondent was doing farming and business (Table 4.1).

Guardian: Findings from this study have shown that half of the respondents were living with their husbands, nine respondents were living with their parents, five respondents were living with mothers while one respondent was living with the sister (Table 4.1).

4.2. Perceptions of male involvement

The first objective of this study was to determine the perceptions of young pregnant women aged 15-19 years on male involvement at ANC. The themes that emerged from the data under perception factor were the negative attitude of men and women; most service providers are women; lack of information or Ignorance; myths and misconception and men's superiority complex.

4.2.1. Negative attitude of men and women

The study found that there is a lot of negativity among men and women towards male involvement at antenatal care clinics. Although the participant showed some interest in the programme they were still able to highlight what they dislike about the programme. They considered fear for HIV test as one of the barrier for MI at antenatal care clinic. Respondents also disclosed that men were doing it deliberately not to attend antenatal clinic. This was evidenced by the following quote;

M: Why do you leave your partners behind?

R: “Some of these men who make us pregnant are very ignorant about the importance of MI and they even fear to be tested for HIV as they are unstable in their ways.”

4.2.2. Most service providers are women

In this study some participants disclosed that some of their partners are very uncomfortable to attend antenatal care clinics because it has been dominated by female service providers. They considered themselves as invaders who are trying to invade the privacy of women in the name of male involvement. On the other hand, findings have shown that some respondents viewed male involvement as good. It was perceived to be helpful during delivery preparation. It was also thought to assist couples learn about ANC and HIV/AIDS. The study found that MI help to increase love and care among couples. Some respondents confirmed this in the following quote;

M: What is the benefit of male involvement?

R: “I think for me; MI has helped me to enjoy my marriage. It has increased our love and care for each other as we are now able to walk together without shame in the road as a couple. We are even able to talk about what to prepare for the baby without conflict. It has really helped me especially the lessons they give us at the clinic when I am with my husband.”

4.2.3. Lack of information / Ignorance

The study revealed that a lot of participants did not have adequate information on male involvement at antenatal care clinic. In trying to find out about the meaning of male involvement, there were very few participants who exhibited knowledge on male involvement. For example;

M: What is male involvement?

R5: “It means that men are accompanying their partners at antenatal care clinic.”

R9: “I see male involvement as the process at ANC clinic that involves testing for HIV, receiving teachings and help to prepare for delivery. I have found that MI assist me to relate well with my husband especially in regard to our HIV/AIDS status and preparing for our upcoming baby. My husband has proven to be helpful in many ways such as reminding me on what we were taught at the clinic when I express ignorance.”

The findings have shown that the respondents got *information about MI from the clinic, community, radio, television* and *parents*. Findings have also shown that *they got information from registered pregnant women and mothers*. One woman said this in confirmation;

M: Where do you get information about male involvement?

R3: "I hear from the people in our community who have been to the clinic for ANC before. I also hear it from the radio and television once in a while. When I came to the clinic, I received more information about MI in a well packaged manner."

Findings of this study have shown that the respondent accessed information from the Health staff at the clinic, pregnant women, mothers and parents. One of the respondent had this to say;

M: How did you access information about male involvement?

R2: "The first time I heard about MI is when I came for my first ANC booking during health education session."

Research findings have revealed that the knowledge of the respondents *on male involvement is not adequate*. One respondent expressed herself as follows;

M: How adequate is your knowledge on male involvement?

R1: "I do not know a lot of things about MI as I am still relying on the health staff to educate me."

Findings from this study have shown that respondents *need to know more about the subject of male involvement at ANC clinic and HIV/AIDS*. One of them put it in this way;

M: Would you like to know more about male involvement?

R6: "I would like to know more about MI at ANC clinic and the best strategies to use to convince my partner to be available during all the required ANC visits even if we are not married."

Another respondent had this to say;

R3: "I would like to know more on how to convince an elderly married partner to accompany their partner to ANC especially in the case of abuse by my guardian."

4.2.4. Myths and misconception

The study also discovered that there are a lot of beliefs that hinder the participation of men in antenatal care clinic. Some of the participants disclosed that they were taught from childhood that antenatal care services are not meant for men because everything that take place there do not concern men. Findings have shown that participants perceived pregnancy as a responsibility of

women. Pregnancy was perceived as a responsibility of both men and women. They put it this way;

M: Whose responsibility is pregnancy?

R1: "Pregnancy is purely women's issue."

R5: "Pregnancy is for both men and women."

4.2.5. Men's superiority complex

The study has also revealed that men are considered to be the head of the household hence they are not supposed to participate in such activities by virtual of their social standing in society. Findings of this study have shown that the participants perceive that men provide financial support, prepare food and clothes. It was also found that men draw water, prepare the needs of the child and escort women as they go to deliver at the clinic. This was expressed in the statement below from one of the participants;

M: What do you think is the responsibility of man while the woman is pregnancy?

R8: "My husband draw water for our home and he carries all the heavy loads when we go to the field. He looks for food and prepares food for our consumption. He even looks for finances to enable us buy clothes and prepare for the baby."

Findings have shown that the participants received help from men. This help included lifting of heavy loads, provision of the much-needed sexual satisfaction and food. The findings also revealed that men provide encouragement in times of despair. This was evidence from this quotation;

M: What type of help do men provide during their partner's pregnancy?

R9: "My husband has been very caring and encouraging since I got pregnant. He has been helping me to do most of the works at home such as cooking, drawing water and even satisfying my sexual need."

Findings of this study have shown that the participants desired that men should carry cassava from the field, prepare the needs of the baby, provide sexual satisfaction, encouragement, clothing and groceries. This was expressed through the following quote;

M: What type of help would you like to receive from your male partner?

R4: "I would like my husband to be more supportive even when it comes to cleaning plates and the house."

4.3. Health Facility dimension factors as experiences

4.3.1. Attitude of health workers

Findings of the study have shown that the respondents are concerned that men will miss a lot of things. The other concern was that it is difficult to prepare for delivery. The women were also worried that they could be chased at ANC clinic. For example, one of the women had this to say;

> M: What are your concerns about male involvement?
>
> R: "It is very difficult for me to convince my partner to escort me for ANC visit because he is in the boarding school which is not in this area. So, I have no choice but to go alone to the clinic and plead with them (health staff) to help me in his absence."

The research findings from the study have shown that involving men in ANC would help to address the concerns. Findings have also shown that engaging elderly people such as parents and in-laws would help to address the concerns of women. This is what one of the women said;

> M: How would these concerns be addressed?
>
> R: "I think that the challenges I face now to convince my husband to accompany me for ANC clinic can reduce by involving elderly people who can easily talk to my husband when he refuses to with me."

4.3.2. Accessibility of services

Findings of this study have shown that the respondents feel that it is bad for women who do not come with their partners. It was also considered to be shameful and that there is less care at the clinic. The findings have shown that it hurts and it worries the woman. This can be confirmed by the following quote below;

> M: What is your experience about the service provided?
>
> R: "I remember when I was coming for my first ANC visit my partner was with his parents in town and I could not manage to convince him to travel for ANC visit. I went along to the clinic but the nurse was not willing to assist me. She told me to go and bring my partner without which I was not going to receive her help."

4.3.3. Cultural values and practice factor as experience

4.3.3.1.Poor communication among spouses

Findings of this study have shown that participants experience barriers against involving their male partners in ANC. Communication breakdown has been pointed out to be a major issue with respect to participation of male partners in antenatal activities. If the couple is not in talking

terms, it proves to be difficult for the woman to convince her partner to accompany her to the clinic for ANC. This was evidenced by the following quote;

M: What barriers did you face to convince your partner to accompany you for ANC?

R6: "I tried by all means to convince my partner to accompany me for ANC clinic but he totally refused and I had nothing else to do except coming alone to the clinic."

4.3.3.2.Traditional belief

Research findings of this study have shown that it is not acceptable in the community for men to be present during the delivery of their wives.

M: Is it culturally acceptable to the community to have men present while their wives deliver?

R2: "It is not culturally accepted at the community to have men in a delivery room."

4.3.3.3.Types of barriers experience

The findings of this study have shown participants experienced different types of barriers which were mainly at the level of the society, the health system and the individual. The most pertinent was the societal perception of antenatal care as a woman's activity, and it was unacceptable for men to be involved. Health system factors such as long waiting times at the antenatal care clinic and the male unfriendliness of ANC services were also identified. Lack of communication within the couple, the reluctance of men to learn their HIV status, the misconception by men that their spouse's HIV status was a proxy of theirs were among the barriers. The unwillingness of women to get their partners involved due to fear of domestic violence, stigmatization or divorce was among the individual factors. The findings of this study have shown that the factors that encourage men to accompany their wives to the ANC clinic include excitement, obedience, teaching and negative HIV results. The factors that hinder men from accompanying their wives to the ANC clinic was found to be bad response at home, women's bad behaviour, HIV test, shame and fear. One participant said this say;

M: What are the factors that may hinder or encourage men from accompanying wives to the ANC?

R2: "According to observation, my husband usually cooperates with me when I respect him and obey his instruction as opposed to the time I decide to be unruly in the home."

4.4. Acceptability

4.4.1. Pregnant women's acceptability of men's presence during ANC

Findings of this study have shown that it is acceptable to pregnant women for men to be present during ANC.

M: Do you find it acceptable to have men present at the antenatal clinic?

R6: "I really do not have a problem with my husband coming with me to the clinic for ANC visit but the people who talk to us discourage my husband."

Findings of this study have shown that pregnant women do not have the desire to be with their partners during delivery. This is what one of the participants had to say;

M: Do you find it acceptable for men to be present while you give birth?

R: "I do not think that men have a role to play we women are giving birth, so I think I would like my partner to be present at a time I am giving birth."

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

This study was seeking to determine the perceptions and to investigate the experiences of young pregnant women aged 15-19 years on male involvement at ANC clinic. It also sought to assess the acceptability of male involvement at ANC clinic among young pregnant women aged 15-19 years.

The overall findings of this study have shown that male involvement is highly accepted even if the male partner attendance remains low. Young pregnant women perceived male involvement at ANC clinics as a good programme that could be helpful to have a healthy pregnancy and safe delivery. It was also clear that the participants expressed increased desire to have the programme continue as it was viewed to be working to their advantage in all aspects of their pregnancy. Findings of this study also indicated that the experiences that they had over the involvement of men in ANC services was a pleasant one. The participants opted to have MI services continue in order to help them resolve some of the domestic challenges that came when the female is tested for HIV alone. In regard to acceptability of MI at ANC clinics, the study found that the services were highly accepted at all levels which included individuals, families and communities at large.

5.1. Perceptions of MI among young pregnant women

5.1.1. Knowledge of young pregnant women on the meaning of MI

This study found that majority of the respondents was 19 years of age. With respect to marital status, this study found that more than half of the respondents were married. There were very few respondents who had a child and who had never been to school. Male involvement among participants was generally considered to be a male accompanying their partner for ANC. This was perceived to be demand from the clinic. Findings of this study also revealed that men are perceived as decision-makers in the home, and feel their position is undermined if they are expected to attend a ‘women’s clinic program’, leading them to decline to attend ANC visits with their partners.

However, MI is not just about promoting men to accompany their partners to antenatal clinic, but for men to provide supportive roles in their families, and also to bring men into HIV preventive and care services. A qualitative study conducted in Western Kenya by Reece et al. found that the distance that the male partners have to travel to the clinics for participating in the education, HIV

tests and counseling, the costs of the transport to the clinics and the amount of time per appointment at the clinic were identified as barriers to male involvement (Reece et al., 2010). Data from another study from Uganda showed that majority of participants said that the health facilities were few and located far from the people, making the health services such as HIV testing and counseling inaccessible.

Some advantages of male involvement as pointed out by the participants include testing for HIV, receiving teachings together and preparation for delivery. In a similar study by Abiodun on 'Women's attitudes toward their partners' involvement in ANC services and PMTCT of HIV' in Quthing district of Lesotho, all the participants were of the opinion that in order to effectively provide PMTCT services, client's partners' should be equally involved and participate actively in the treatment while rendering the necessary support for such a family. It has been argued that stress and lack of supports have been linked to the progression of HIV infection. In order to prevent this, the participants were unanimous in their believe that pregnant women, nursing mothers and their partners should be encouraged and supported, offering counselling, HIV care and treatment where necessary (Abiodun, 2014). In this study it was equally found that all the relevant stakeholders especially their partners are key in the successful implementation of male involvement programmes.

5.1.2. Knowledge gap of young pregnant women on MI

In regard to areas of knowledge needs, respondents expressed willingness to learn more about MI at ANC clinic and other ANC services. This is important for the success of the MI programme. Morfaw et al. (2013) argued that within the health system, capacity reinforcement and motivation of the health service providers could improve the quality of services and minimize long waiting times within antenatal care clinics. In this study they identified 24 studies from peer-reviewed journals; 21 from sub-Saharan Africa, 2 from Asia and 1 from Europe. Barriers to male PMTCT involvement were mainly at the level of the society, the health system and the individual. The most pertinent was the societal perception of antenatal care and PMTCT as a woman's activity, and it was unacceptable for men to be involved. Health system factors such as long waiting times at the antenatal care clinic and the male unfriendliness of PMTCT services were also identified. The lack of communication within the couple, the reluctance of men to learn their HIV status, the misconception by men that their spouse's HIV status was a

proxy of theirs, and the unwillingness of women to get their partners involved due to fear of domestic violence, stigmatization or divorce was among the individual factors.

Actions shown to facilitate male PMTCT involvement were either health system actions or factors directly tied to the individuals. Inviting men to the hospital for voluntary counseling and HIV testing and offering of PMTCT services to men at sites other than antenatal care were key health system facilitators. Prior knowledge of HIV and prior male HIV testing facilitated their involvement. Financial dependence of women was key to facilitating spousal involvement. Most often than not, resources are usually in short supply and antenatal clinics especially in developing countries are usually inadequately staffed (Yeganeh et al., 2014). Efforts need to be made to target the best use of available resources. One option may be the differential counseling for HIV infected women to bring along their husbands. Another may be the selective counseling of men presenting at delivery wards. Irrespective of the methods chosen, such selective measures may not only minimize time wastages, but may also ensure that limited resources and manpower are concentrated upon the population most likely to benefit from the interventions. Still within the health system, the offering of VCT during non-working hours has been identified as a means to improve male uptake of PMTCT interventions (Abuhay et al., 2014). The use of alternative but acceptable HIV testing sites was also suggested. The implication of these suggestions within the health system is the careful consideration of the cost-effectiveness and acceptability of any interventions before implementation.

5.1.3. Implications of lack of knowledge on MI by young pregnant women

The study found that the participants in the focus group discussion considered pregnancy as a responsibility of women. This is a hindrance to the promotion of MI in ANC clinics. It was also noted that the participants perceived the responsibilities of a man to include financial support, food preparation, clothing, water drawing, help to lift heavy loads, provide encouragement in times of despair, provision of sexual satisfaction, preparation of the needs of the baby and escort women to deliver at the clinic. This is helpful to the promotion of MI in ANC clinics. In regard to community perception for men helping women, it was found to be normal for men to help women in their respective communities. However, other studies reveal that the need to preserve masculinity and authority is a deterrent to male involvement in ANC clinics (Kalembo et al., 2013); men do not want to be seen walking with their partners to the health facility, because the

community perceives that such men are under their partner's control. Hostile attitudes of health workers are a deterrent to male involvement (Kim et al., 2014); traditionally nurses have barred men from coming near the labour wards and delivery rooms in a bid to protect the privacy of the women. As a result, men who are aware of these restrictions prefer to keep away from their partners during pregnancy and birth related procedures in order not to conflict with health workers.

The lack of knowledge about HIV and the importance of male involvement in PMTCT have direct implications for information, education and communication initiatives (ORGANISATION, 2010). It highlights the need to increase male education on HIV/PMTCT and target information for men by various means. Examples of these sensitization activities include the pasting of flyers and posters in areas frequented by men, and use of the media to discuss and encourage male participation in HIV/PMTCT. The knowledge barrier also calls for increased training of health educators and the revision of educational messages provided by health counselors so far (Morfaw et al., 2013). Hence, counselling messages within ANC services should address spousal communication regarding sexual risks. It should also encourage women to discuss VCT with their spouses before testing, and help them to elaborate plans to involve their partners early in PMTCT. The message that a woman's HIV status is not a proxy measure of that of her partner should be emphasized.

Although increasing levels of knowledge of ANC has shown a positive influence on male involvement (Kinuthia et al., 2010), male involvement in ANC in this study was deterred by community awareness of procedures at the health facilities. Men knew that presenting at antenatal clinics with their partners for a routine pregnancy check also meant having an HIV test and this presented the following challenges: Firstly, the decision to undertake an HIV test is difficult for many men because in case of an HIV positive result there is no assurance of immediate treatment, care or other benefits. Non-male focused ANC programs that leave men with inadequate services have resulted in low male involvement in ANC (Kandala et al., 2011). Thus, men feel that there is no reason for a premature investigation of their HIV status, at least not until they are very ill and AIDS is suspected. Even when AIDS is suspected the first line of resort is the traditional healer (Youngleson et al., 2010). It is estimated that 70% of the population in Sub-Saharan African accesses traditional healers as their first choice of health care. Traditional healers are held in high esteem as they are thought to provide the spiritual

interventions required to bring about health improvements (Klot and Nguyen, 2011). Although it has been demonstrated that traditional healers are able to incorporate HIV prevention in their clinical practice, there are challenges to successful collaborations between traditional and biomedical sectors (Kuman, 2014).

Secondly, a man accompanying his wife for ANC raises curiosity in the community about the results of the HIV tests, whether or not the tests were taken. This curiosity is raised because of the multiple sexual partnerships, results of one individual are a proxy indicator of the HIV serostatus of another sexual partner (Kiula et al., 2013). Multiple concurrent sexual partners have been identified as one of the drivers fueling the HIV epidemic in Uganda and that in central regions of Uganda, men were likely to have more than eight sexual partners in their lifetime; the number of sexual partners increased with increasing wealth quintiles (Kim et al., 2014).These partnerships are an impediment to male participation in HIV prevention services, as observed in this study; and as previously noted there has been insignificant funding for interventions that address underlying social norms (Lassi and Bhutta, 2015). Thirdly the fact that the male partner has tested with the wife will mean that he has to disclose to the wife, yet men traditionally disclose to their fellow men. Fourthly , fear of stigmatization in case of positive HIV test result is a deterrent for both men and women alike (Lolekha et al., 2014). Fifthly, although disclosure has resulted in partner support of adherence to PMTCT recommendations elsewhere from experience women know that disclosure of an HIV test result raises further questions on the reasons why they decided to take the test, and often has led to disruption of marriages; therefore women are reluctant to request their partners to participate in programs that require HIV testing, or even to present letters of invitation from the health facility because they would have to explain how they got to the facility, and what they shared with the health workers, leading to the invitation (Kim et al., 2014).

Previous studies have also found that men are uncomfortable with reversed role of women as bringers of health information to the home and would prefer other men to provide such information. The decision to take an HIV test is therefore one that is thought over very carefully and cannot be made instantly in a setting where no clear benefit for the man is at hand (Muchemi, 2014). Therefore, as long as male involvement in ANC simply means that men accompany their partners and undertake an HIV test, then men will continue to resist participating in this program since it disrupts their social networks. At the level of the health

system these findings imply there is a need for reinforcement of the strategies used, if any, to improve male involvement in ANC clinics. There is need to actively invite and involve men in ANC activities through different means (Morfaw et al., 2013). These efforts of engaging men should consider the health and other needs of men rather than simply portray them as tools for women's or infant's health outcomes.

5.1.4. Experiences of young pregnant women on MI

In regard to the experiences of respondents, it was discovered that the women who did not come with male partners at ANC clinic received less care from the clinic and that some were even ashamed and cased. This was perceived to be a bad experience that some young pregnant women had gone through. Experiences of this nature were a source of worry and hurt for some young pregnant women. The main reasons for worries and hurt feelings were that men were missing a lot of information that would be helpful in preparing for delivery. The other reason was that some young pregnant women were requested to go and bring their male partners for them to be attended to at ANC clinic. However, it was learnt that engaging elderly people and in-laws would help to address the concerns at household level but that this was not addressing the health institution. According to the systematic review study by Morfaw et al. (2013) on MI in prevention programs of mother to child transmission of HIV, health service changes rendering ANC and PMTCT services more male-friendly are necessary. These could include the implementation of couple antenatal counseling and testing as a routine within the health service, the reorientation of services towards both sexes, the possibility of couple/individual testing, the strengthening of couple counseling outside routine antenatal care, and the creation of male-friendly spaces within the ANC premises amongst others (Falnes et al., 2011).

5.1.4.1. Barriers of MI experienced by young pregnant women

Regarding barriers of MI experienced by young pregnant women at antenatal care clinic, the respondents cited ignorance. Other barriers cited were fear for HIV test and work while some respondents felt that it was deliberate that some men did not attend antenatal care clinic. The level of education has a major role in the promotion of male involvement in various facilities of Mwense district. In this regard, the illiteracy level of the communities visited impact negatively on the promotion of MI at ANC. Ignorance would equally entail lack of understanding on the importance of the service that are offered at ANC clinic such as PMTCT services which result in

fear to be tested hence shun the service. In addition, since there is less value attached to the services provided at ANC clinic, men do not take these services serious thus they opt out deliberately. At the same time, some men chose to be at work rather than attending ANC clinic due to their failure to appreciate the services provided.

Morfaw, et al. (2013) identified 24 studies from peer-reviewed journals; 21 from sub-Saharan Africa, 2 from Asia and 1 from Europe. In this study, barriers to male involvement in PMTCT were mainly at the level of the society, the health system and the individual. The most pertinent was the societal perception of ANC and PMTCT as a woman's activity, and it was unacceptable for men to be involved. Health system factors such as long waiting times at the antenatal care clinic and the male unfriendliness of PMTCT services were also identified. The lack of communication within the couple, the reluctance of men to learn their HIV status, the misconception by men that their spouse's HIV status was a proxy of theirs, and the unwillingness of women to get their partners involved due to fear of domestic violence, stigmatization or divorce was among the individual factors.

Although respondents experienced these barriers to MI at ANC clinic, they expressed interest to have the programme continue. It is their desire that men should continue to show love and care. This is in agreement with the study conducted in Quthing district of Lesotho by Abiodun (2014) which contended that over 80% expressed that men should show more love to the women when pregnant, and 68% of women are of the opinion that the presence of their partners' at antenatal clinic showed their concern and care. Improving communications between partners can be achieved through community discussions, acceptance, and the realization that both men and women have a role to play in plugging the communication gaps (Abiodun, 2014). In this study, what came out clearly is that women viewed antenatal care as important to having good pregnancy result and they see it as an avenue to get tested. Majority of the women (68%) were in support of their partners' involvement in antenatal care. The staffs of MCH were in total support of this. Cultural factors and gender based beliefs were found to be hindering male involvement in PMTCT programme and getting tested for HIV. The results also show that the staffs of MCH have positive attitudes towards people living with HIV. There were some respondents that did not know the barriers of MI in ANC services. However, there were respondents who perceived MI to be helpful in preparing for delivery, assist to learn about ANC services, to know HIV status and help increase love and care from male partners which is highly sort for.

5.1.5. Acceptability of MI at ANC clinic by young pregnant women

Several studies have reported negative perceptions towards men attending ANC services. In one report, men who accompanied their wives to ANC services were perceived as being dominated by their wives (Jennings et al., 2014). Frequently men perceive that ANCs services are designed and reserved for women, thus are embarrassed to find themselves in such "female" places (Byamugisha et al., 2011). Certain women too, do not like to be seen with their male partner attending the ANC service. A study conducted in Kenya showed that certain male clients trust traditional healers but not hospitals and therefore do not attend ANC clinics (Reece et al., 2010). In this study, with respect to pregnant women's acceptability of men's presence during delivery, the study found that the participants do accept the presence of men at ANC clinic. In view of Health Staff's acceptability of men's presence during ANC, the participants disclosed that it is acceptable to staff for men to be present during ANC.

In regard to general acceptability of men's presence during delivery or at antenatal care visit, the participants indicated that generally it is acceptable for men to be present during ANC clinic. When asked about pregnant women's desire to have men's presence at ANC clinic, the participants came out that pregnant women have the desire to have men present during ANC clinic. In regard to community acceptability of men's presence during delivery, all the participants revealed that it is not culturally acceptable in the community for men to be present during delivery or ANC clinic. It is clear that improvement of ANC services by making them more male friendly, and health education campaigns to change beliefs and attitudes of men are absolutely needed (Ditekemena, 2012).

5.1.6. Limitations of the study

The following were the limitations of this study;

- The non-involvement of men in the study that are within the desired age range of 15 – 19 years as their perception might vary with those of young pregnant women of the same age range.
- This study was conducted in Mwense district of Luapula province setting. The findings can reflect the views of young pregnant women in that setting but may not reflect the views of young pregnant women in other settings.
- In addition, ascertaining the genuineness of responses provided by the study participants is a daunting challenge in research and this study has no exception.

- The analysed information had been translated into English, which could have diluted the original richness of the data including possible loss of information. This was however minimized by ensuring that translation was done by experienced data collectors as soon as each interview was accomplished.
- Convenient sampling was used which may not give the most suitable sample for the study.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

In conclusion, even though most respondents expressed the need to involve men in ANC, some women were open to dislike men's physical presence at ANC clinics. Male involvement is not just about promoting men to accompany their partners to antenatal clinic, but for men to provide supportive roles in their families, and also to bring men into HIV preventive and care services. Male involvement provides an opportunity to couples' testing and counselling. Disclosure to partner is made easy and may not yield violence, a man may care for his partner if she tests positive. This may support and encourage adherence to antiretroviral treatment (ART). Studies generally support male involvement to promote EMTCT, but the nature and impact of that involvement is unclear and untested. Additionally, stigma, disclosure and intimate partner violence pose significant barriers to PMTCT uptake and retention in care, suggesting that male involvement may be 'necessary at ANC clinics, but not sufficient' to reduce HIV incidence. There are no previous studies in this setting that have focused on male involvement at ANC clinic.

It was clear that the respondents were well knowledgeable on the benefits of male involvement and that they would like to have the programme continue. However, some of the respondents confessed that they had scanty knowledge about male involvement as a subject. The subject of male involvement at the clinics left them with different experiences that were both negative and positive. The negative experiences made participants to have bad perception about the overall programme. However, positive experiences helped them to realise that the programme was meant for good and mainly to benefit them. This enabled them to have positive perception about the programme. It was also clear that the respondents perceived male involvement at ANC clinic as a good practice that would improve their lives and relationships. The respondents also indicated that failure to involve men in ANC clinic was bad and had serious consequences such as reduced care from clinic staff and shame when sent away.

In this study, it was found that male involvement helps to prevent marital conflict especially when the HIV test results come out to be positive. MI creates a conducive environment for discussing issues of HIV/AIDS such as prevention, treatment and care. It was also found that pregnancy was mostly considered to be the responsibility of women than men. Therefore, men's

presence during delivery of their partners was not acceptable by pregnant women and the community except by health staff. However, the study revealed that male involvement is key to the improvement of health status of pregnant women. MI is supportive to couples who are found to be HIV positive. Thus, the importance of male involvement at ANC clinic cannot be over emphasised.

It is therefore important to work with community leaders and encourage men to participate in ANC activities. ANC services need to be made more male-friendly to encourage more men to attend with their spouses. The clinics should offer specific activities in which men can participate and try to adjust clinic hours to accommodate men's schedules. Health education aimed at breaking cultural barriers should also be instituted for men by government and nongovernmental organization as a possible way to address underlying gender norms and societal attitudes towards male involvement in ANC activities. Hence community-based programs that would normalize male participation and minimize associated stigma need to be initiated.

6.2. Recommendations

The interventions should be put in place to target patriarchy and other hindrances to MI at ANC clinic. The following recommendations would be helpful towards the improvement of male involvement at antenatal care clinic based on the findings of this study;

1. There is need to increase sensitization on the meaning of MI at ANC clinic to young pregnant women.
2. Since some participants perceived pregnancy as a responsibility of women, there is need to create awareness in order to change this perception.
3. There is need to conduct a study on the perceptions, experiences and acceptability of male involvement at ANC clinic among men who have married young pregnant women aged 15 – 19 years.
4. A study to look at the effects of male involvement policy on staff workload is needed.
5. Health personnel should find a way of promoting MI through the elderly people and in-laws to avoid sending young pregnant women away.
6. Health personnel should be sensitized and trained on how to handle delicate medical issues like HIV to ensure that young pregnant women do not feel uncomfortable or unwanted at any one time especially when in the health facilities.
7. There should be a deliberate policy to support male-friendly Health Facilities.

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ANNEXES

Annex 1: Information Sheet

TITLE OF THE STUDY: PERCEPTIONS AND EXPERIENCES OF YOUNG PREGNANT WOMEN AGED 15 – 19 YEARS ON MALE INVOLVEMENT AT ANTE NATAL CARE CLINIC IN MWENSE DISTRICT, LUAPULA PROVINCE, ZAMBIA.

You are asked to participate in a research study conducted by Wilson Kapenda Mwape, Post Graduate Degree in Public Health at The University of Zambia, School of Medicine. The study will be conducted in partial fulfilment of a Master of Public Health. You were selected as a possible participant in this study because you are pregnant and you are within the targeted age group.

Mwaipushiwa ukuibimbamo mumasambililo yafyakufwilisha palwaakuibimbamo kwa bashibantu muchipatala chaba namayo abalipabukulu ayalechitwa na Wilson Kapenda Mwape umusambi wa pa University of Zambia, Mwisukulu lyafyabumi ngefilefwikwa pakupwisha amasambililo.

PURPOSE OF STUDY: The study is designed to identify young pregnant women' perceptions and experiences on male involvement at antenatal clinic in Mwense District of Zambia. It is hoped that the study will help establish their perceptions and experiences. It will also identify the extent to which male involvement supports antenatal care services in this age group, and where possible offer recommendation towards the improvement of antenatal care service delivery.

Ayamasambililo yabelo paku fwaya ukwishiba ifya banamayo abali pabukulu bapitamo nokutontonkanya pakuibimbamo kwa bashibantu mu chipatala chabanamayo abali pabukulu. Kabili chilekabilwa ukwishibikwa ifyo ukuibimbamo kwa bashibantu kwaafwa ichipatala chabanamayo abali pabukulu elyo ngachasuminisha no mona ifyo ichichipatala chingayilako pantanshi.

PROCEDURES: If you volunteer to participate in this study, the researcher would ask you to respond to questions from the in-depth interview or focus group discussion guide on your perceptions and experiences regarding male involvement at antenatal care clinic. The interviews and focus group discussion will be audio recorded.

Ngachakuti mwaipela ukuibimbamo muli aya amasambililo, abasmbi balemwipushako ukwasukako kumepusho yenu mweka nagula ayamwibumba pafyo mwapitamo nofyo

mutontonkanya pakuibimbamo kwa bashibantu mu chipatala chaba namayo abali pabukulu. Ukukulanshanya kulelembwa namukalimba.

POTENTIAL RISKS AND DISCOMFORTS: The study does not have any potential risks although discomforts may be experienced during responses to some questions and a bit of your time that will be taken as you answer the questions. In addition, participants will not be forced to share information that they are not comfortable to disclose and have the right to ask that certain information be omitted if they want.

In the event that any participant experiences discomfort, the researcher will stop the questions and allow for such information to be omitted. Depending on the circumstances, the researcher will avoid questions that may seem to cause discomfort to any participants and allow for withdrawal of participants where necessary.

Muliuku kulanshanya tamuli ifingaletobwafya, lelo kuti kwabako ukukana umfwabwino pakwasuka amepusho yamoyamo kabili nokusendako akashita panono pakwasuka amepushio. Chimbi, abakuibimbamo tabalepatikishiwa ukwasuka amepushio eyotabalefwaya kabili nabakwataensambu shakwipusha ukuti yambi amepushio yeipushiwa.

Ngachakuti kwabaubwafya, ukulanshanya kwiminina nokufumyamo ifileleta ubwafya. Bakepusha bakulashako amepusho ayegaleta ubwafya elyo panshitaimoyine abakuibimbamo nabakwata insambu shaku kanatwalilila ngabasangamo ubwafya mukwasuka amepusho yaleipushiwa.

POTENTIAL BENEFITS TO SUBJECTS AND TO SOCIETY: Potential benefits for participating in this study include enhancing the participant's knowledge on male involvement at antenatal care clinic. Participants will be able to contribute to the recommendation where possible on how male partners could be encouraged to attend antenatal care services with their women and thereby benefit from its implementation. This will ultimately improve the utilization and quality of ANC.

Ubusuma buli mukuibimbamo bwakwishibilapo nafimbi pakuibimbamo kwa bashibantu mu chipatala chabanamayo abali pabukulu kabili no shanshako amano yengafwa uyu mulimo ukuyapantanshi mu kukoselesha bashibantu ukulaibimbamo mu chipatala chabanamayo abalipabukulu no kukwatako ichakaniko kufisuma ifitumbuka mulishimilimo.

PAYMENT FOR PARTICIPATION: There are no monetary benefits for participating in this study. However, by participating in the study, you will contribute to information that will assist

the District Medical Office to consider community opinions as they implement programmes. Therefore, the time you will spend in discussing the issue is highly appreciated.

Muliuku ukuibimbamo takuli ulupiya ululepelwa kuli imwe lelo muleafwilisha ukupela ilandwe ilyakwafwa abakubumi ukumwafwa bwino ilyo mwatandalila chipatala chabanamayo abalipabukulu. Echo chakutotela sana panshita mwapela kuliuku kulanshanya.

CONFIDENTIALITY: Any information that is obtained in connection with the study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by ensuring that information collected from the participants will not be directly linked to individuals. Your identity will be kept anonymous by using a number to identify you instead of your name. If the need for counseling should arise, provision will be made for counseling services. The trained counsellors will be on hand to offer counseling and psychosocial support.

Ilandwe lyonse ililesendwa kuliimwe paliukukulanshanya kabili ilikumine kuli imwe likasungwa mubumfisolo kanofye mwasuminisha ukupelakobambi nangu kukukabilwa kwefunde. Fyonse ifishibilo fyenu tafyakasuntikanishiwe nelandwe lyenu pantu amanambala eyakubonfya mukumwishibiliko lelo temashina yenu. Abasambilishiwa pafyakulanshyanya nabantu abali nobwafya balepekanishiwa pakwafwilisha nga kwaba ubwafya ubulibonse.

VOLUNTARY PARTICIPATION: You can choose whether to be in this study or not. Your participation in this study is purely voluntary. If you volunteer to be in this study, you may withdraw at any time without consequences or penalty of any kind. You may also refuse to answer any questions that you do not want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

Ukuibimbamo muliukukulanshanya kwa kuipeleshafye kashi namukwataensambu shakusumina nangu ukukana ukwabula ubwafya ubulibonse. Elyo kabili ngamwaipela ukuibimbamo, namukwataensambu shakuleka inshita iliyonse ukwabula ukupatikishiwa nangu ukuchushiwa ukulikonse. Elyo kabili ngamulefwaya teti mwasuke amepushioyambi lelo mwatwalilila ukuba muliuku ukulanshyanya ukwabulanobwafya. Elyo kabili ngachasuminisha, bakepusha kuti bamifumyamo muliuku kulanshana.

INFORMATION AND CLARIFICATION: Please be informed that if you need clarifications at any time over the research study, direct your questions to:

Napapata nganamukwata amepushio palwesambililoeli, ipusheni amepusho ku malembelo yapelwe pesamba apa:

WILSON KAPENDA MWAPE
THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF PUBLIC HEALTH
P.O. BOX 50110
LUSAKA
CELL # 0977676778/0967676778/0950226812
Email: kapendamwape@yahoo.com
OR
THE CHAIRPERSON
ERES CONVERGE (PRIVATE REB)
33 JOSEPH MWILWA ROAD
RHODES PARK, LUSAKA.
Tel: +260 955 155 633/4
Cell: +260 966 765 503
eresconverge@yahoo.co.uk

RIGHTS OF RESEARCH PARTICIPANTS: You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

Kuti mwafuma muliuku ukulanshanya inshita iliyonse ukwabula ubwafya ubulibonse nangu ifyakupingulwa ifilifyonse. Ukuibimbamo kwenu takulemipelako insambu, ishuko nangu umuti uliwonse.

Annex 2: Participants' Consent/Assent Form

The purpose of the study has been explained to me and I fully understand what is involved in this study. I have volunteered to participate in the study out of my own free will, and that I am free not to answer questions I may deem personal or otherwise and to withdraw at any time.

Signed: _____ Name: _____ Date: _____

Witness: _____ Name: _____ Date: _____

(May use right thumb print if unable to sign)

Annex 3: Parents'/Guardians' Consent Form

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF PUBLIC HEALTH

Informed Consent Form for Parents/Guardians/Husbands

(This is the form is for participants aged 15 years)

Study Title: PERCEPTIONS AND EXPERIENCES OF YOUNG PREGNANT WOMEN AGED 15 – 19 YEARS ON MALE INVOLVEMENT AT ANTE NATAL CARE CLINIC IN MWENSE DISTRICT, LUAPULA PROVINCE, ZAMBIA.

Principal Researcher: WILSON KAPENDA MWAPE

THIS IS TO CERTIFY THAT I _____ (name of participant/guardian) HEREBY agree to have my child/wife _____ (Child/Wife's name) participate in the above project.

I hereby agree that my child/wife be interviewed in relation to the study needs. I understand that the information may be published but the names and identity will not be associated with the results.

I understand that I am free to deny permission to include my child/wife in the study. I also understand that I am free to withdraw my consent and terminate the participation of my child/wife at any time without penalty. I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

_____ _____ _____ _____

Signature of Parent/Guardian Witness Signature Researchers Signature Date

(May use right thumb print if unable to sign)

Annex 4: Permission Request letter

C/o Department of Public Health

School of Medicine

University of Zambia

LUSAKA.

1st June 2015

The Permanent Secretary

Ministry of Community Development Mother and Child Health

LUSAKA

UFS: The Head, Department of Public Health.

Dear Sir,

RE: Request for permission to conduct research from your Health Facilities.

I am a student at the University of Zambia, School of Medicine pursuing Master of Public Health. I am required to conduct a research study as partial fulfillment of the program.

In this regard, I am requesting for permission to conduct my study from your health facilities.

The proposed research will look at perceptions and experiences of young pregnant women aged 15 – 19 years on male involvement at ante natal care clinic in Mwense District of Luapula Province.

Your favorable response will be greatly appreciated.

Yours faithfully,

Wilson Kapenda Mwape

MASTER'S STUDENT, DEPARTMENT OF PUBLIC HEALTH

Annex 5: In-depth interview guide for young pregnant women aged 15-19 years.

A. PERSONAL INFORMATION/PROFILE

Instruction: Please respond to these questions with your information

1. Age: When were you born? ……..
- Imyaka: Nilisa mwafyelwe? ……....
2. Are you married? …….
- Bushe mwaliupwa? …….....……..
3. If yes, when were you married? ……...
- Mwaupilwelisa nga mwaliupwa? ……
4. How many children do you have? ……...
- Mwakwata abana banga? …….
5. Do you live with all your children? ……..……
- Bushe mwikala nabo abana benu bonse? ……..……
6. What is your highest qualification? …….....
- Bushe mwafikapesa mwisa mumasambililo yenu? .....
7. What do you do for a living? ……
- Bushe nifinshi muchita mu bwikashi bwenu? ……..……
8. Where do you live? ……..…….
- Bushe mwikala kwisa? ……..……...
9. Who do you live with? ……
- Bushe mwikala nabanani? ……..

B. KNOWLEDGE

1. What would you say is male involvement at ante natal clinic? Probe

- Bushe kuti mwalandaposhani pa kuibimbamo kwaba shitata muchipatala cha banamayo abalipabukulu?

2. What do you consider to be the benefits of male involvement at ante natal? Probe

- Kuti mwatilati busuma nshi bwaba mukuibimbamo kwaba shitata muchipatala cha banamayo abalipabukulu?

3. What do you consider to be the barriers of male involvement at ante natal clinic?

- Bushe kuti mwatilati finshi fichinga bashitata ukukana ibimbamo muchipatala cha banamayo abalipabukulu?

4. Would you like this arrangement to continue? Why?

- Bushe kuti mwatemwa ukuti ukukupekanya kwatwalila? Ninshi?

C. PERCEPTIONS AND EXPERIENCES

1. What do you think about male involvement at ante natal? probe

- Bushe mutontonkanyapo shani pakuibimbamo kwabashitata muchipatala cha banamayo abalipabukulu?

2. What is your opinion about women who come with male partners at ante natal clinic?

- Bushe kuti malandaposhani Pali banamayo abesa naba lume kuchipatala cha banamayo abalipabukulu?

3. How do you feel about women who do not come with their male partners?

- Munfwashani nga banamayo tabeshile naba lume kuchipatala cha banamayo abalipabukulu?

4. Are you concerned about women who fail to convince their male partners to accompany them to ante natal clinic? Probe, if yes, why?

- Bushe mulasakamikwa nabanamayo abafilwa ukukoselesha bashitata ukusangwa kuchipatala cha banamayo abalipabukulu? Ninshi?

5. What are the concerns? How do you suggest having your concerns addressed?

- Nifinshi ifimisakamika? Kuti yapwa shani amasakamiko yenu?

6. What would be your reaction if male partners attend antenatal care services with their women?

- Bushe kuti mwachitapo shani ngachakuti bashitata batendeka ukulasangwa kuchipatala cha banamayo abalipabukulu?

D. SOURCE OF INFORMATION

1. What is your source of information concerning male involvement at ante natal?

- Bushe nikwisa mufumya ilandwe lya pa kuibimbamo kwaba shitata muchipatala cha banamayo abalipabukulu?

2. How do you access information on male involvement at ante natal?

- Bushe ilandwe lya pa kuibimbamo kwaba shitata muchipatala cha banamayo abalipabukulu mulisanga shani?

3. How adequate is your knowledge on male involvement?

- Bushe fingi mwaishibapo pa kuibimbamo kwaba shitata muchipatala cha banamayo abalipabukulu?

4. What areas would you like to receive more knowledge in?

- Bushe nifinshi mwingatemwa ukwishibilapo pa kuibimbamo kwaba shitata muchipatala cha banamayo abalipabukulu?

5. Is there anything that you would like to discuss concerning the above topics?

- Bushe kuli ifyo mwinga temwa ukulandapo paliuyu umutwe welyashi?

Thank you. (Twatotela).

Annex 6: Focus Group Discussions (FGDs) Guide

Broad Questions and Probes:

1. Do you think that pregnancy is purely a women's issue, or is pregnancy something that both men and women should be involved in?
   - Bushe ukwimita ifumo mulimo wabashitata nabanamayo, kuti mwetontonkanyapo shani?
2. What do you think are the roles and responsibilities of a man while his female partner is pregnant?
   - Bushe mukutontokanya kwenu, milimonshi abaume bakwata elyo abenamyaabo balipabukulu?
     a. What do your partners do to help you with your pregnancies?
   - Bushe bwafwilishonshi abenamyenu bamipela ilintu muli pabukulu?
     b. What would you like your partners to do to help you with your pregnancies?
   - Bushe nifinshi mwingatemwa abalume benu balemwafwako ilyo muli pabukulu?
     c. Is it seen as normal for a man to help his female partner while she is pregnant in your community?
   - Bushe chilamoneka ichayana shitata ukwafwe namayo wakwe lintu alipabukulu munchende mwikalamo?
     d. Have you experienced barriers against involving your male partner in ANC?
   - Bushe mwalitala shingwanapo namafya mukuibimbamo kwakwa shitata wenu kuchipatala chabanamayo abalipabukulu?
     e. If yes, what barriers have you experienced?
   - Ngamulesumina, mafyanshi mwashingwanapo nayo?
3. How would you describe a "good husband"?
   - Bushe kuti mwamulondolola shani umulume umusuma?
     a. What do you think are men's roles in ensuring that their wives have a healthy pregnancy and delivers a healthy baby?
   - Bushe mulimonshi iyomwingatontonkanya bashitata bengabomba pakuti abenamyaabo bakwate ubumi ubusuma lintu balipabukulu no kukwata umwana umumi?
     b. Do men accompany wives when they visit the antenatal clinic (ANC)?

- Bushe bashitata balashindika abenamyabo kuchipatala chabanamayo abalipabukulu?

c. Point out factors that may hinder and/or encourage men from accompanying wives to the ANC.

- Londololeni ifingakoselesha nangu ukutompola bashitata ukushindika abenamyabo kuchipatala chabanamayo abalipabukulu.

4. Do you think that men are always supportive of their partners, or do they become more supportive and involved when their partners are pregnant?
   - Bushe mulatontonkanyati abaume balafwilishya abenamyabo lyonse, nangu balafwilisha saana ilintu balifye pabukulu?
     a. Do you think that male partner support is helpful for HIV adherence?
   - Bushe mukutontonkanya kwenu ubwafwilisho bupela bashitata bulafwilisha mukukonkwa kwakunwa umuti wakashishi kabulwele bwakondoloka?
5. Is there space in the clinic for men, or do they have to wait outside the clinic?
   - Bushe mwalibenchende yabashitata muchipatala nangu balolela panse pachipatala?
     a. Did your partners come with you to your antenatal visits?
   - Bushe abenamwenu balesa naimwe kuchipatala chamafumo?
     b. Did they come inside the clinic, or did they wait outside until you were finished?
   - Bushe balingile muchipatala nangu balelolelafye panse mpaka mwapwisha?
     c. If men wait outside the clinic, why do you think this happens?
   - Bushe nga bashitata balelolela panse, kuti mwatontonkanya ati ninshi chibela ifi?
     d. What do men do while they wait?
   - Bushe nifinshi bashitata bachita ilyo balemilolela?
     e. How would the health care providers treat men if they were present?
   - Bushe ababomfi bachipatala kuti batangata shani bashitata ngabalishile?
6. Do you think that it would be acceptable if a man was present when his partner gave birth?
   - Bushe kuti mwatontonkanya ati kutichasuminishiwa nga shitata asangilwe apalepapila abenamwakwe?

a) Would other pregnant women find it acceptable?

- Bushe bambi banamayo abalipabukulu kuti basuminisha ifi?

b) Would the staff at the clinic find it acceptable if a man came with his partner to the clinic for antenatal visits?

- Bushe abababomfi bapachipatala kuti bachisuminisha icha kwa shitata ukwisa nomwinamwakwe kuchipatala chabanamayo abalipabukulu?

c) Is it more acceptable for a man to be present at antenatal visits or when his partner gave birth, or are both equally acceptable?

- Bushe fyonse fibili kuti fyasuminishiwa nangu chimofye ichingasuminishiwa?

d) Would you like your partner to be present when you give birth?

- Bushe kuti mwatemwa abenamwenu ukusangwapo ilyo mulepapa?

e) In your community, is it acceptable for a man to be present when his female partner gives birth?

- Bushe umomwikala chalisuminishiwa abaume ukusangwako ukulepapilwa abenamwabo?

f. Is there anything else anyone would like to say about this topic or the other topics we've discussed today?

- Bushe kuli abasheleko nefyakulandapo nangu ukwipushapo pafyo twalanshanya lelo?

Thank you. (Twatotela).