GENDER NORMS, ATTITUDES AND PERCEPTIONS TOWARDS MALE INVOLVEMENT IN MATERNAL HEALTH IN KAFUE DISTRICT

BY

MWANSA MWENYA

A dissertation submitted to The University of Zambia in partial fulfilment of the requirements for the award of Master of Arts in Gender Studies.

THE UNIVERSITY OF ZAMBIA

LUSAKA

2019
DECLARATION

I, Mwansa Mwenya, do hereby declare that this dissertation is my own original work and any other work referred to has been duly acknowledged. To the best of my knowledge, no other similar piece of work has been presented or previously published for any academic purposes at the University of Zambia.

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APPROVAL

This dissertation by Mwansa Mwenya is approved as fulfilling the requirements for the award of degree of Master of Arts in Gender Studies of the University of Zambia.

Examiner 1 __________________________ Signature _________ Date ______________

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Board of __________________________ Signature _________ Date ______________

Examiners

Supervisor __________________________ Signature _________ Date ______________
ABSTRACT

Employing both quantitative and qualitative paradigms, the study sought to investigate the gender norms, attitudes and perceptions towards male involvement in maternal health in Kafue district. Despite the efforts by the Ministry of Health in ensuring that national health policy guidelines in Zambia are put in place and demand male participation in maternal health services, the response is still low when it comes to accompanying due to work demands, gender norms, attitudes and perceptions. Quantitative data was collected using closed ended questions from 140 respondents which was processed and analyzed using SPSS version 23. Qualitative data was collected using in-depth interviews from 10 respondents. Qualitative data was analyzed by emerging themes and Nvivo10. Among other things, the study revealed that generally men and women from Kafue were more knowledgeable on antenatal care. In the study it was also revealed that respondents had a positive attitude towards male involvement however, due to gender norms theirs roles were limited when it came to delivery and child care. However, the findings show that men were involved in supporting their wives and helping out with house chores and providing money for skilled birth at a hospital and postnatal care. Men who were married were more likely to be involved in maternal health than men who were not married. The study also revealed that men were not comfortable with discussing their wives pregnancy with a health care provider due to lack of privacy. Reflection on the findings seems to suggest that there were many factors affecting male involvement in maternal health. Lack of messages and programs targeting men, health staff attitude during delivery, gender norms such as men were not allowed to attend to women when in labor. In the study it was also revealed that men and women had a positive perception towards pregnancy being a shared responsibility, men supporting and caring for their wives during and after delivery. Although a high proportion of male respondents in Kafue were aware of antenatal and postnatal care services, the number of male spouses who actually accompanied their partners for delivery and postnatal care was low. Kafue District Health Office should take steps to raise awareness through community outreaches and extend the service to the weekend so as to accommodate men who work during the week.

Key words: Gender norms, Attitudes, Perceptions, Male involvement, Maternal health.
DEDICATION

This document is dedicated to my parents Iven B. Mwenya and Joseph Mwenya. Amazing support rendered by my sisters Julia, Inutu, Nabiana and friends Christabel, Joy and Belinda.
ACKNOWLEDGEMENT

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<td>Antenatal care</td>
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<td>CSO</td>
<td>Central Statistical Office</td>
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<td>FP</td>
<td>Family planning</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>PNC</td>
<td>Postnatal care</td>
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<td>RHS</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>VCT</td>
<td>Voluntary counselling and testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>ZDHS</td>
<td>Zambia Demographic Health Survey</td>
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CONCEPTUAL AND OPERATIONAL DEFINITIONS

- **Attitude** refers to someone's opinions or feelings about something, especially as shown by the behavior (Mayor et al. 2006).
- **Cultural beliefs** refer to norms and values that a particular ethnical or tribal group of people follow dutifully.
- **Gender** refers to a set of characteristics that are either seen to distinguish between male and female, one's biological sex and one's gender identity (Holmes, 1998).
- **Gender norms** social expectations of appropriate roles and behaviors for men and women. The reproduction of these norms in institutions and practices, are directly related to men's health-related behaviors, their families and their children (Kimmel and Messner 1989, Campbell 1995, Cohen and Burger 2000).
- **Maternal health** refers to health of women during pregnancy, childbirth and the postpartum period (WHO, 2009)
- **Men’s participation/ involvement** refers to men's active involvement in issues around them. In this study, men's participation is measured on the basis of the following:
  i. Initiating discussion about antenatal care issues with their partner
  ii. Alleviating the workload, providing information and support to the female partner
  iii. Accompanying partner to antenatal clinic on all visits
  iv. Making preparations for birth
  v. Being aware of the critical pregnancy danger signs and what exactly to do about them
- **Perception** immediate or intuitive recognition or appreciation of something. In this study, perception is viewed in the area of recognizing and appreciating issues of maternal health (Oxford, 2004).
- **Sex** refers to biological and physical differences between men and women as they get classified as ōmale and ōfemale (Oxford, 2004).
- **Spouse/partner** men or women who are either married, living together or who are sexually involved and have children together
- **Utilization** was used to mean effective and correct use of reproductive health services among adolescents
CHAPTER 1
INTRODUCTION

1.1 Introduction

This chapter provides the background to the study, the problem on which the study was based and its objectives including research questions. The purpose of the study, significance of the study and operational definitions of key words used in the study are also highlighted in this chapter.

1.2 Background

Every year some 585,000 women worldwide die as a result of pregnancy related complications and childbirth (Mayokun, 2015). Most of these maternal deaths are preventable however, maternal mortality prevention programs have focused on the provision of services such as training midwives, developing and stimulating community-based maternal healthcare systems and improving healthcare facilities (Carter, 2002). Little attention has been paid to increasing demand for these services. Unlike other health services, the direct beneficiaries of maternal health care are not in a position to access the services without the active involvement of their spouse and other family members.

The woman’s ability to have a safe and healthy pregnancy and delivery implies that pregnancies should be planned for by both the man and woman while the woman is in the best of health. UNICEF’s Safe motherhood initiative (2007) to increase male involvement in promoting maternal health care has proved futile. Several studies have shown that lack of male involvement in maternal health has contributed to the slow decrease in maternal deaths (WHO, 2007).

Evidence shows that infants whose mothers die are more likely to die before reaching their second birthday than infants whose mothers survive (WHO, 1995). There is slow progress towards achieving the third Sustainable Development Goal (SDG) in developing countries. With an estimated 483 deaths per 100000 live births Zambia’s maternal mortality rate is a lot higher than the Sustainable development goal set target of 162.3/100000 live births by 2030 (Silver and Singer, 2014).
Such deaths are not only deeply rooted in the provision of poor quality services, attitudes of health personnel and accessibility, but also gender in relations between men and women. Gender norms are social expectations of appropriate roles and behaviors for men and women and the reproduction of these norms in institutions and practices, are directly related to men’s health related behaviors, (Cohen and Burger, 2000). Strengthening male involvement in maternity care is cardinal not only to meeting gender needs of pregnant and nursing women but also to reducing maternal mortality, (Mullick et al, 2001; WHO, 2002). According to the African journal on reproductive health(2012) male involvement in maternal health care has been described as a process of social and behavioral change that is needed for men to play more active roles in maternal health care with the purpose of ensuring women’s and children’s wellbeing.

Since the mid-1990s, when the International Conference on Population and Development (ICPD) in Cairo and the International Conference on Women in Beijing urged gender equality and equity through empowerment of women and highlighted the importance of involving men in reproductive health programs, there has been an increasing appreciation of the significant benefits for the health of men, women and children (WHO, 2007).

In response to global action plans adopted at the two conferences initiatives have been implemented in many parts of the world concerning 4 main goals, to increase men’s awareness of and support for family planning; to increase men’s awareness of the need to safeguard the reproductive health of their partners and themselves, especially through prevention of sexually transmitted infection; to improve access to men’s contraceptive methods for couples who are interested in using them; and to improve men’s access to comprehensive reproductive health services (Eastern Mediterranean health journal, 2006).

Despite growing awareness and political will in some settings, actual progress towards increasing the engagement of men in maternal and child health has been slow in developing countries. In developed countries, the role of the expectant father has only recently begun to be addressed for example in Sweden the father’s involvement in maternal and child health care is emphasized in legislation (Bernloehr et al, 2005). Fathers have also been invited to participate in antenatal classes, preparing them for the experience of birth (Hanson et al, 2009).
Many countries face challenges at the implementation level and more research that draws together examples of interventions that have successfully increased male involvement are needed. UNICEF (2009) States of the World’s Children report notes: In the field of maternal and newborn health, men are generally missing from the literature.

Literature shows that most reproductive health programs focused on family planning which is exclusively offered to women (Greene, 1995). Most programs, viewed women as the target group and paid little attention to roles that men might have had in respect to women’s reproductive health, decision-making and behavior. In recent years, a number of family planning and women’s health programs began to acknowledge that family planning and women’s health must be viewed in the broader context of reproductive health and the involvement of men in maternal programs (Greene et al, 2004).

A review by Dudgeon & Inhorn (2004) on roles of men with regards to women’s reproductive health showed that men influence decision making and involving men has a positive impact on family planning, infertility, abortion and sexually transmitted infections. However, there is a gap in information on men’s intentions and practices as they relate to pregnancy and childbirth, more qualitative research is needed to include men as a major part of women’s social environments in both pre- and post-natal health (Dudgeon & Inhorn, 2004, p. 1388).

Men are an important focus for family planning, safe motherhood and reproductive health services, not only because they are decision makers in the home, but because their participation, attitude and behavior affect women’s reproductive health (Ntabona, 2002). Nakamboa (2008) discovered that involving men in reproductive health has a positive impact on women’s health in a number of ways, including improving maternal and child health care, preventing or reducing sexually transmitted diseases and AIDS transmission. Studies have shown that involving men can increase contraceptive adoption, contraceptive continuation, birth preparedness and postnatal continuation.

According to a study carried out by Centre for African Family Studies in urban and rural areas of the Copperbelt Province in Zambia 1999, men were found to be marginally involved in child health and maternal care. Therefore, men still face challenges in participating in maternal health. To increase male involvement and participation in reproductive health, there is need to
understand and respect the gender norms, attitudes and perceptions of the community which are affected by personal, social and cultural factors (Kols and Sherman, 1998). The Knowledge of the community and the people’s attitudes and perceptions is important to increasing male involvement in maternal health as there can be an improvement in designing and implementing community interventions.

1.3 Purpose of the study

The purpose of this study was to investigate the gender norms, attitudes and perceptions of men towards maternal health because this may affect their active involvement and utilization of maternal health services in Zambia.

1.4 Statement of the Problem

Male involvement in maternal health remains a major issue despite efforts by the international community. In order to increase male involvement the government through the Ministry of Health introduced reproductive health services with a minimum package of male involvement in 2000 (Integrated Reproductive Health Plan of Action 2003-2005: MoH, CBoH, 2002.). Despite the many benefits of male involvement in antenatal care there has been an observed low participation.

Community Gender norms, attitudes and perceptions towards male involvement in maternal health may affect the utilization of services offered by health facilities. The gap in these studies is that the attitude and perception of men regarding maternal health have largely been neglected.

There is limited research on gender norms, attitudes and perceptions of male involvement in Zambia. Most efforts appear to have concentrated on reproductive health services that promote sexual and reproductive health which focus on women. There is need to investigate the gender norms, attitudes and perceptions of men towards male involvement in maternal health so as to increase the active participation of men in maternal health.
1.5 Research Objective

a) General Objective

To investigate the gender norms, attitudes and perceptions towards male involvement in maternal health in Kafue district.

b) Specific Objectives

a. Assess the level of knowledge in maternal health among men and women
b. Examine the gender norms, attitude and perceptions of men and women in maternal health
c. Establish factors associated with attitudes, involvement and perceptions of male involvement in maternal health.

1.6 Research questions

I. What is the level of knowledge in maternal health among men and women?
II. What are the gender norms, attitudes and perceptions of men and women in maternal health?
III. What are the factors associated with attitudes, involvement and perceptions of male involvement in maternal health?

1.7 Significance of the Study

By investigating gender norms, attitudes and perceptions towards male involvement in maternal health the study will help in understanding how men choose to use the numerous reproductive health services offered. In addition the study will help to develop and improve the delivery of maternal health care in Kafue in a more efficient manner. Furthermore it has been observed that addressing gender norms, attitudes and perceptions can lead to improved client satisfaction, continued and sustained use of services and improved health outcomes (Bertrand et al. 1995; Kols & Sherman 1998; Vera 1993) and help formulate policy recommendations on how to improve male participation in maternal health in Kafue.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The importance of involving men in reproductive health has gained increased recognition in literature, especially after the 1994 Cairo and 1995 Beijing consensus documents, which agreed that men are crucial to bringing about changes in mother’s health status (Lee, 1999). However, most existing literature on men's involvement in maternal health is about family planning, Prevention of mother to child transmission and antenatal care. No much documentation has been done with regard to male involvement in providing support to a woman during the maternity cycle and after delivery.

Therefore, this chapter provides relevant literature related to male involvement in maternal health. The literature focused on level of knowledge in maternal health, gender norms, attitudes and perception of male involvement and social, economic and demographic factors that are associated with attitude and perception of male involvement in maternal health. The theoretical and conceptual framework used in the study is presented in this chapter.

2.2 Level of Knowledge of Men in Maternal Health.

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

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

Globally a number of related studies have been done to determine the level of knowledge in men
with regard to their involvement in maternal health. A study by Rakibul and others (2009) on
Antenatal and Postnatal care seeking behavior on the Garo tribe revealed that availability of
services in a community did not necessarily reflect the care seeking behavior unless awareness
about the available services among potential clients was increased. Additionally women's
decision-making power regarding their health issues can improve the situation further and men's
attitude towards women in a specific society or community determines the women's health care
seeking behavior (Rakibul et al, 2009).

Men play critical roles in women's ability to seek health care, yet more often than not, they are
uninformed about women's reproductive health needs or their own. It is believed that when male
and female are aware of each other's health needs, they are more likely to receive services. It is
imperative to note that to increase male involvement in maternal health services requires the
providers to gain in-depth knowledge and understanding of the men's health perspectives,
behavior and practices (Mutua, 2004).

According to Rosen and others (2002), the benefits of involving men in women's reproductive
health services are well recognized and have been advocated for by many. Millick et al (2005)
stated that with respect to obstetric care, it is often the family and not the woman alone who
makes decisions. Men are the obvious target audience because in many cases, they control the
cash reserves or their permission needs to be obtained for obstetric care-seeking (Millick et al,
2005; incite Dallabetta et al, 1997). Lack of involvement by men deprives women of their
partners' care and support in coping with pregnancies and in making appropriate infant feeding

A longitudinal study conducted in the United States in 2002 explored the effect of father
involvement during pregnancy on receipt of prenatal care. The findings of the study indicated
that women whose partners were involved in their pregnancy care were 1.5 times likely to attend
prenatal care in the first trimester as opposed to those whose partners were not involved in their
pregnancy care (Martin et al, 2007).
In another study; involving men in maternity care in India by Varkey (2004) during the Frontiers Men in Maternity (MiM) which "encouraged husbands' participation in their wives' antenatal and postpartum care" as a response to the findings that men as primary household decision makers had an impact upon women's health. A sample survey of eligible men and women attending the MiM antenatal clinics was conducted in the clinics and then again at home when their infant was six months old to measure the effectiveness of the intervention by comparing women and their husbands to those of eligible couples from the three control clinics. Results from this study showed that the MiM intervention of involving men was able to raise awareness and use of family planning (FP) in the postpartum period, and also increased awareness of dual protection for STIs. In this case, the more people become aware and knowledgeable about the service, the more they were able to utilize the service (Varkey et al, 2004).

In Africa, the Men in maternity Care study was implemented in KwaZulu-Natal in South Africa by Mullick and others in 2001 with the aim of establishing whether it was feasible to involve men in antenatal and postnatal care, and whether this would be acceptable to health care providers, clients and their partners. The study revealed that some men admitted that they lacked knowledge because their partners did not tell them what they learnt from the clinics. Men felt it was important to be informed and were willing to be involved in most aspects of maternity care. This showed that men lacked knowledge and therefore could not utilize the service (Mullick et al, 2001).

A similar study conducted in two rural clinics in Tanzania in 2007, aimed to describe the prevalence and predictors of male partner participation in HIV voluntary counseling and testing and the effect of partner participation and uptake of HIV prenatal intervention. The findings of this study indicated that zero-positive mothers whose partners attended voluntary counseling and testing after being encouraged to inform and invite their partners were 3 times more likely to use nivarapine prophylaxis, 4 times more likely to avoid breast feeding and 6 times more likely to adhere to the feeding method selected than those whose partners did not attend voluntary counseling and testing (Msuya et al, 2008).

In Zambia a study conducted by Tshibumbu (2006) in Mambwe district focused on factors influencing men’s involvement in prevention of mother to child transmission programs. Further
the reasons behind low involvement among men in reproductive health services particularly in PMTCT services were investigated. In this study the factors studied were grouped as knowledge and awareness, socio-cultural, programmatic and demographic characteristics. The major findings were that knowledge of PMTCT was the strongest factor which was positively associated with the level of men's involvement in PMTCT services before and after delivery (postnatally).

Another study done in Chipata, Zambia also reveals that males were not fully participating in PMTCT and reasons given were lack of information and lack of direct link between PMTCT staffs and males (Benkele, 2007). Nakamboa, (2008) in a qualitative study conducted in Kafue through focus group discussions discovered that men are not motivated and traditionally not encouraged to participate in reproductive services. Other factors like poor husband and wife interaction which makes it difficult for men to understand reproductive problems of women, men reproductive health needs, men’s discomfort to visit clinics with their wives because of cultural myths and men’s discomfort to discuss reproductive health issues with service providers were also identified (USAID, 2006).

2.3 Gender Norms, Attitudes and Perception of Men in Maternal Health

The goal of maternal health care is to ensure that no woman or new born dies or incurs injuries due to pregnancy or child birth. However to achieve this goal, maternal health service providers and planners need to view this service in the context that women’s potential to control and improve their wealth as well as their health is more limited than men’s in most parts of the world (Engender Health, 2008). However, traditional or current gender norms that moderate against male involvement are in many communities. Constructions of masculinity in patriarchal societies often limit the ways in which men are allowed to engage in pregnancy, birth and child rearing. In many societies social space is not afforded to men who want to engage more in care taking and those who do are often stigmatized or discouraged (Dumbaugh et al, 2014).

Culturally, childbirth is a woman’s business. Men are characterized as resource providers for the family including health care. The man is restricted to accompanying the wife to the hospital. He may take her on a bicycle so as to avoid delay and the woman giving birth along the way. Further the man is to inform the woman’s relatives that the wife was in labor and organize for a female
guardian, (African journal of reproductive health, 2012). A male gendered role norm during the pregnancy, childbirth and postnatal period is to provide emotional, material and financial support to his spouse. Men around the world have been portrayed as economic providers and decision makers (Carter, 2002; Muia et al., 2000).

Societal allocation of roles to the men and women especially decision making influences utilization of antenatal care. It is therefore important for men to understand and appreciate the importance of attending antenatal care services at a health facility. A study done by Britta et al (2004) in Nepal revealed that only 40% of the husbands accompanied their women attending antenatal care for the first time and that greater decision making power for women was associated with lower husband accompaniment to antenatal care and lower overall male involvement. Consequently men’s involvement in the maternal health care system often stops at the doors to the clinic, yet to exclude men from information on the benefits of antenatal care, counseling and health services is to ignore the important role men’s behaviors and attitudes may play in a woman’s maternal health choices (Platin, 2007, Lester and Moorsesom, 1997, quoted by Britta, 2004).

Men do not seek health information and services due to traditional notions of masculinity, where asking for help from a health provider is viewed as a sign of weakness. It is not uncommon in most African societies for men to decide as to when and how a woman should seek care. A study done among Garo people of India revealed that cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities (Nyamongo, 2003).

Available literature indicates that how patients view and experience the quality of care they receive is an important determinant as to whether or not they choose to utilize health services (Benjamin et al 1995). It is very common to hear of people preferring to go to certain clinics whether private or public as a result of what they may perceive as good friendly health care services. For instance there is evidence that has been found suggesting that women’s decisions to visit reproductive health facilities and use contraceptives are influenced more by levels of satisfaction with services than other factors including distance to clinic, household wealth and family size (National Library of Medicine, 2009).
A study by Romero-Gutierrez and others in 2003 on postpartum contraceptive acceptance in Leon, Mexico was carried out with the aim of identifying the reasons for the acceptance or rejection of contraceptive methods among postpartum women at the Hospital. The findings revealed that one of the most prominent reasons for contraceptive refusal were husband's rejection (33.2%). Further the results showed that the rejection of contraceptives was mainly attributed to husbands' negative attitude about the use of the contraception (Romero-Gutierrez et al, 2003).

In Nepal, a study on Barriers to and attitudes towards promoting husbands' involvement in maternal health by Mullany (2005) discovered that the most prominent barriers to male involvement in maternal health included low levels of knowledge, social stigma and job responsibilities. Though providers also predicted some obstacles in the form of hospital policy, manpower and space problems, providers consistently felt the option of couples-friendly maternal health care would enhance male involvement. The predominantly favorable attitudes of pregnant women, husbands, and providers towards encouraging greater male involvement in maternal health in this study implied that the introduction of an option for such services would be both feasible and well accepted (Mullany, 2005).

Barua, suggests that negative attitudes of health care providers are a major problem in most developing countries especially towards male involvement in reproductive health (Barua, 2004). The traditional attitude of health workers, coupled with notices in the health care premises, for example, "men are not allowed in the labor ward" discourages men from giving support to their wives in Antenatal care and labor (Mullany, 2005).

A similar study on ANC /PMTCT services was done by Byamugisha et al (2010) to determine male involvement in the prevention of mother-to-child transmission of HIV (PMTCT) program in Mbale district, Eastern Uganda. The study results showed that the majority (74%) had a low male involvement index and only 5% of men accompanied their spouses to the antenatal clinic. This was attributed to the men's low education levels. Men who had attained secondary education had a high male involvement index than those who had primary or no formal education. A negative attitude from men was common, as demonstrated by the majority because
of cultural beliefs. Identified barriers in the study influenced the attitude and utilization of reproductive health services (Byamugisha et al, 2010).

Further, antenatal staff attends to couples first before attending to the mothers who come alone, as one way of encouraging couple attendance. This practice shows that traditional women-centered services in the first place are not organized, in a way that the waiting time issue is addressed. However, the time issue is only addressed when men are involved. This may reflect the notion that antenatal clinic is a women’s space such that the health care workers would want to attend to the man as fast as possible and free him from the feminine environment (Myburgh, 2011).

A study conducted in Tanzania by Theuring and others assessing male attitude regarding partner involvement concluded that some men do not escort their spouses to maternal clinics because it is not their role, they only do so when their partners are not feeling well. However some men showed a positive attitude towards male involvement as they stated that it helped them gain knowledge on important issues. This however shows that men with a positive attitude are more likely to attend the maternal health visits and learn more about reproductive health (Theuring et al, 2009).

Some men do not attend the antenatal visits for fear of being perceived as a jealous husband following his wife around, and in some cases, men do not attend the antenatal visits for it would make their relationship with their pregnant partner publicly known hence limiting their chances with a potential girlfriend (Natoli, 2012).

A study in Malawi revealed that male involvement in maternal health is perceived as couples HIV counseling and testing (African journal of reproductive health, 2012). This perception is in line with the recent upsurge interest of involving men in HIV prevention, mainly PMTCT. However, research in this area has shown that pregnant women who accept HIV testing, a substantial number never return for results, interventions for PMTCT, or antiretroviral treatment (Kululanga, 2012). This practice may discourage the men, especially those who may not want to have an HIV test and those who already know their HIV status. Similar findings were also reported by Finnbogadottir (Chikonde et al, 2009).
In Zambia factors such as distance to the health facility, income levels of individuals and households act as barriers to health services even though they may think quality care at a health facility is good (Nakamboa, 2008). In one of the surveys that tried to measure employee attitude on health care discovered that attitudes shifted due to current events, changing media coverage and campaigns, new employer health strategies and higher out-of-pocket costs (Harris Interactive inc: 2006).

Rebecca Wolfe in her article *Health Systems Reporter: focus on patient’s perceptions of quality of care* noted that to increase access and utilization of reproductive health care, it is important that patient perceptions of quality of care are taken into account when evaluating services, and that services are responsive to their needs and expectations (Wolfe et al., 2007). She strongly advocates that providers should not only ensure clinical factors such as safe procedures, accurate information and reliable products but also to respond to patient cultural values, social concerns and individual needs (Wolfe et al, 2007).

A study by Kaseba and Chirwa revealed that although most facilities offer a wide range of reproductive health services, the perceptions of what constitutes reproductive health services differs from place to place. Further it reported that despite poor staff attitudes, long distances covered and waiting times over 90% of clients in the study reported to be satisfied with the care they received (Kaseba and Chirwa et al, 2004).

### 2.4. Factors Associated with Attitude and Perception of Male Involvement

Socio-economic characteristics of members of the community work as background variables that influence the perceptions and attitudes towards the use and quality of care of reproductive health services (Mutemwa, 2011). More often than not, people of certain social class are more likely to have different preferences in accessing health services. For instance clients who have certain disposable income prefer to go to private hospitals for their reproductive health services just to avoid what they may perceive as congestion at a government health facility (Kaye et al, 2014).

The Reproductive Health Working Group of Population Council Regional Office for West Africa and North Africa reported some findings on reproductive health services but no mention was made to the direct association of perceptions, behaviors and attitudes towards such services.
Their findings were that social, culture and economic constraint in men’s and women’s lives do affect their ability to access health care and that women did not only have an unexpectedly high level of reproductive disease, they also have a very low level of health awareness and a very low level of health care uptake (The Policy Services in Reproductive Health No.6: 2000).

A Nigerian study by Adeleye and Chiwuzie (2007) shows that attitudes and practices such as providing money for maternal care, border on economic support. However, where such care is not given, it may be difficult to determine whether it is a situation of true financial neglect or one of frank poverty. In this study poverty may be a reason why a man may send his pregnant wife to live with her mother, hence avoiding the financial responsibility of care (African journal of reproductive health, 2007).

Kaye in a study on male involvement during pregnancy and childbirth: men’s perception practices and experiences (2014) discovered that despite the existence of a supportive policy for male involvement, men experience stressful situations in their attempts to be involved during pregnancy and childbirth. There is a disagreement between societal expectations and men’s experiences, as well as disagreement between the policy for male involvement and the practice in the health system. The health system’s policy that advocates for male involvement, and the contemporary societal expectations that men should be as involved as possible in pregnancy, childbirth and childrearing contrast sharply with the reality (Kaye et al,2014).

Nevertheless, providing motivational information, ensuring positive provider attitudes and providing educational support in a pleasant environment to men are potential interventions to increase male involvement in maternal health care. Feyisetan (2000) discovered that education played a significant role in spouse communication. Spouse communication about contraceptive use is greatly enhanced when both spouses have similar levels of education (or close to one another) (Feyisetan, 2000). The significance of education is much more pronounced when none of the partners have below secondary education and at least one of them has a post-secondary education. Such type of couples usually have access to mass media, internet and exposure to the outside world, factors that influence behavior change (Kinanee and Ezekiel, 2009).

Spouse communication is associated with the empowerment of women within the marital union. A number of factors indicate the empowerment of women and the increase of their status within
the household and the marital union (Speizer, Whittle and Carter, 2005). With little difference in educational attainment, partners appear to feel more comfortable discussing issues which are traditionally thought to be under the control of men. Thus, education and exposure to the western culture influence couple’s attitudes and behavior towards increased gender equity (Mbekenga et al, 2011).

In almost all the studies that have been done on Reproductive Health service, not a single one has tried to directly assess how individual perceptions and attitudes do affect the utilization of reproductive health services when they are provided to communities conducting client surveys and patient flow studies could help to improve the daily provision of care and, hence client satisfaction (Mangwaza S, Cooper D, M. Hoffman et al., 2000).

2.5 Theoretical Framework.

In order to fully understand the underlying issues of male involvement in maternal health care, the study used the Precede and Proceed Model (Green, 1999). PRECEDE is the Predisposing, Reinforcing and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation which leads up to the intervention.

Predisposing factors are those factors that motivate or provide a reason for a given behavior; they include knowledge, attitudes, cultural beliefs, and readiness to change.

Enabling factors are those that enable a person to act on their predispositions; these factors include available resources, supportive policies, assistance and services.

Reinforcing factors are those which come into play after a behavior has been initiated; they encourage repetition of behaviors by providing continuing rewards or incentives. Social support, praise, reassurance and symptom relief might all be considered reinforcing factors (Green, 1999)

PROCEED defines how to proceed a defined intervention; it spells out Policy, Regulatory, and Organizational Constructs in Educational and Environmental development. This model focuses on the community as the source of male involvement, and is based on the foundation that the change process should focus initially on the outcome, not on the activity. This model assumes that since behavior changing activities that individuals engage in are almost always voluntary,
carrying out health promotion has to involve those whose behavior or actions one wants to change.

To understand the perceptions of men towards their involvement in maternal health, the four assessment phases of PRECEDE were undertaken as follows:

Phase 1: Identification of the ultimate desired outcome: this comprised a definition of male involvement.

Phase 2: Identifying the issues and factors that might influence the outcome: this comprised an assessment of the behavioral, lifestyle or environmental supports for and barriers to male involvement.

Phase 3: Identifying the influencing, enabling and reinforcing factors that affect the behaviors, attitudes, and environmental factors identified.

Phase 4: Identifying the administrative and policy factors that influence what can be implemented. PROCEED on the other hand focuses on implementation and evaluation of a designed intervention.
2.6 Conceptual Framework

Figure: Precede and Proceed model

Note:

SA= social assessment (phase 1), BA= behavioral assessment (phase 2) EEA= educational and ecological assessment (phase 3), APA= administrative and policy assessment (phase 4), I= implementation (phase 5) PE= process evaluation (phase 6), IM= impact evaluation (phase 7) OE= outcome evaluation (phase 8)
CHAPTER THREE

METHODOLOGY

3.1. Introduction

This chapter highlights the research design and approach employed in this study. It discusses the study design, study site, study population, sample size and sampling procedures, data collection instruments and method of data analysis.

3.2 Research Design

The study used a descriptive study design which enabled the researcher give a clear picture of what occurs naturally. The design involved observing and describing the behavior of men and women without influence from the researcher. The study design was chosen because descriptive research provides an account of the characteristics of respondents in real-life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs and categorizing information (Burns and Grove, 2009).

3.3 Research methods

Both quantitative and qualitative research methods were used. Quantitative method was used to collect demographic and numerical data so as to generalize it across a group of people and explain a particular phenomenon. While qualitative method was used to establish people’s feelings; it was humanistic and delved into their opinions on the research topic. This approach allowed for in-depth, flexible and broad coverage since it was dealing with human beings who were able to express their feelings and in an effort to obtain a deeper understanding of gender norms, attitudes and perceptions towards male involvement.

3.3.1 Qualitative Method

Qualitative method was used to collect information through in depth interviews. A total of 5 men and 5 women were interviewed through in-depth interviews. This method was chosen because of its usefulness in the exploration of people’s knowledge, views and experiences (Kitzinger, 1994). Qualitative data collection approach was used to collect data that would reveal patterns of feelings and emotions that underlie male involvement.
3.3.2 Quantitative Method

Aliaga and Gunderson (2000), defines quantitative research as explaining phenomena by collecting numerical data that is analyzed using mathematically based methods (in particular statistics). In this study quantitative method was used to collect information on the socio economic and demographic background of the respondents so as to assess the levels of knowledge and identify factors that influence the attitudes and perceptions. Further it was used to measure the level of knowledge of the respondents. A total of 140 respondents were interviewed through structured questionnaires of which 70 were men and 70 were women.

3.4. Study Area

The study was conducted in Kafue District which had an estimated population of 219000 of which 108,939 are males and 110,061 are females. The population for the reproductive age group of 15 ÷ 49 was 62,365 (CSO, 2010). Kafue District was chosen because it had one government District Hospital which received referral cases from the local clinics and was utilized by the majority of the population. Further Kafue is a semi-rural area which represents characteristics of both urban and rural areas thereby enabling the researcher to gather data from people with different socio economic status and cultural backgrounds.

3.5 Study population

In this study the population included women and men who were receiving or attending maternal health clinic. The study targeted respondents who were utilizing maternal health care at the hospital and local clinics. The aim was to design a sample that was representative of the population receiving maternal health care at Kafue District Hospital.

3.6 Study Variables

3.6.1 Dependent variables

Dependent variables in this study included knowledge on maternal health, attitude towards accompanying partner to antenatal, involvement in family planning, involvement in attending antenatal clinic with partner, involvement in making sure children are completely immunized and perception that pregnancy was a shared responsibility.
3.6.2 Independent variables

The independent variables included socio-economic and demographic characteristics of respondents; these were marital status, education level of the respondents and employment status.

3.7 Hypothesis

The study tested three hypotheses to prove association between variables.

1. Married men are more likely to have a positive attitude towards male involvement in maternal health.

2. Educated men are more likely to be knowledgeable on maternal health.

3. Unemployed men are likely to be involved in attending antenatal clinic with partner.

3.8 Inclusion criteria.

The study included women who were receiving antenatal and postnatal care and men who were fathers and had attended antenatal care and postnatal care with spouse.

3.9 Exclusion criteria

- Men who were not yet fathers during the study period and had never attended antenatal or postnatal clinic.
- Women who did not have children under the age of five

3.10 Sample size

The target group for this research was already defined however; both probability and non-probability sampling procedures were used. Probability sampling was used to pick the respondents for the structured questionnaires whereas non-probability sampling was used to pick the respondents for the in-depth interviews. The sample size for the study was calculated using the formula:
\[ n = \frac{z^2 \times p \times (1-p)}{d^2} \]

Where:

- \( n \) = sample size
- \( z \) = confidence level
- \( p \) = prevalence
- \( d \) = margin error.

Since the population of women and men attending and utilizing maternal health care in Kafue was unknown, this formula was therefore ideal. According to the WHO calculator while keeping the confidence level at 95\% (\( z \)), an associated prevalence of 89\% (\( p \)) and a margin error of 0.05 the calculated sample size was 150.4.

\[ n = \frac{1.96^2 \times 0.89 \times (1-0.90)}{0.05^2} \]

\[ n = 150.4 \]

The maximum sample size obtained was 150. The participants were selected using systematic sampling from Kafue town. In order to have an equal number of respondents from both wards in Kafue the sample size will be divided by half

\[ = \frac{150}{2} \]

\[ = 75 \]
3.11 Sampling strategy

A list of the wards in Kafue district was acquired from Central statistics office (CSO). Purposive sampling was used to pick two wards one rural and one urban so as to draw a sample that is representative of Kafue district. The study targeted one respondent per household either an expecting mother or mother or an expecting father or father.

Shabusale and Lukolongo wards were sampled. A mapping obtained from Central Statistics Office (CSO) on Lukolongo and Shabusale wards acted as a sampling frame from which the households were drawn. Shabusale ward had 250 households while Lukolongo ward had 125 households. In order to pick the required number of households which would provide the respondents in the sample size, systematic random sampling was used. A frequency interval was required which was calculated using the following method.

Therefore, Frequency interval = Total number of households

\[ \frac{N}{SN} \]

Respondents in Shabusale ward = \( \frac{250}{75} = 3.33 \)

This meant that each 3\textsuperscript{rd} house was sampled for either a male or female respondent in Shabusale ward.

Respondents in Lukolongo ward = \( \frac{125}{75} = 1.66 \)

This meant that each 2\textsuperscript{nd} house was sampled for either a female or male respondent in Lukolongo ward.
The first household to be sampled was selected randomly and the remaining households in Shabusale and Lukolongo were picked every 3rd and 2nd interval respectively. The target was one respondent per household however, if one household had both a male and female respondent present at the time of the interview they were both interviewed though at separate times so that the respondent could freely express their view on the research topic without interference or intimidation from their partner. The most difficult to find were men due to their busy schedules, the men interviewed in this study were therefore not necessarily the partners of the women interviewed. If the household picked did not have any eligible respondent disproportionate sampling with replacement was used.

For the in-depth interviews snowball sampling was used. The 1st person was picked purposively. This was because the first person to be interviewed needed to have had enough knowledge and be able to provide appropriate references of other individuals that would provide additional data on male involvement in maternal health.

Thereafter, each successive participant was selected through snowball sampling. Snowball sampling is a process where the next participant to be interviewed is ‘recommended’ by the person who had just been interviewed. Snowball was particularly useful in this case because it provided the needed reference to other individuals who in turn provided the right information.

Each respondent offered consent to participate and be interviewed privately. The women and men were recruited from their homes.

3.12 Data Collection methods

Structured questionnaires and in-depth interviews were used.

3.12.1 Structured questionnaires

Quantitative data was collected using a structured questionnaire which had closed ended questions. One hundred and forty (140) questionnaires were administered through personal interviews. The questions in the questionnaires were based on the type of questions used in maternal child care research programs across the globe Zambia inclusive.
3.12.2 In-depth interview

Apart from the structured questionnaires, the research also based its data collection from 10 in-depth interviews. The recruitment of participants was done from men and women who did not answer the questionnaire. Five male respondents and five female respondents participated in the face to face in-depth interviews. This helped collect data on the attitudes and perceptions towards male involvement from a gendered perspective so as to understand why male involvement in maternal health care has not reached parity in Kafue.

3.13 Data analysis

Data collected from the questionnaires was cleaned and coded to ensure well organized processing. Quantitative data obtained through questionnaires was analyzed using Statistical Package for Social Sciences (SPSS). This generated frequency tables and cross tabulations. Qualitative data obtained through in depth interview was analyzed using thematic analysis. Interviews were recorded and then transcribed when the interview was complete so as to clean the data. Emerging themes that were important to the description of the research and associated with a specific research objective were identified across the data set and categorized accordingly. NVIVO software assisted in the organization of themes from the data set which aided the researcher to analyze the data.

3.14 Ethical considerations

Ethical clearance was sought from the Directorate of Research and Graduate Studies (DRGS) ethics committee at the University of Zambia. Permission to conduct the study was sought and granted from Kafue District Health Office and Verbal or written consent was sought from participants after the purpose of the study had been explained to them. Confidentiality and privacy was observed during data collection. Questionnaires were coded instead of names being used.

3.15 Limitations of the study

The study was restricted to respondents in Kafue hence challenges for generalization to other areas. The in-depth interviews did not involve health providers hence failing to capture their views.
CHAPTER 4
PRESENTATION OF FINDINGS

4.1 Introduction

This chapter presents the findings of the study collected through questionnaires and in-depth interviews. Findings from questionnaires are supported with tables and figures while those from in-depth interviews are supported with actual words used by the respondents.

4.2 Socioeconomic and demographic information of the respondents.

Out of the total number of 150 respondents interviewed, 75 were male and 75 were female. 75 respondents were interviewed from Lukolongo ward in Kafue while another 75 respondents were interviewed from Shabusale ward in Kafue.

4.2.1 Age of the respondents

The respondents were asked to indicate their age. As shown in Table 1 majority of the respondents 46.4% were in the age group 31 to 45. 44.3% of the respondents were in the age group 16 to 30 and minority 9.3% was in the age group 46 to 60.

Table 1 Age distribution of respondent by sex

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male %</td>
<td>Female %</td>
</tr>
<tr>
<td>16 - 30</td>
<td>11.4%</td>
<td>32.9%</td>
</tr>
<tr>
<td>31 - 45</td>
<td>29.3%</td>
<td>17.1%</td>
</tr>
<tr>
<td>46 - 60</td>
<td>9.3%</td>
<td>0</td>
</tr>
<tr>
<td>total</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>
4.2.2 Marital status of the respondents.

Table 2 shows the marital status of the respondents according to sex. The results showed that 82.1% were married while 11.4% were cohabiting or dating and 6.4% were separated.

Table 2 Marital status of the respondents

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Sex</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>Married</td>
<td>46.4%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Cohabiting/ dating</td>
<td>2.1%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Separated</td>
<td>1.4%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Total</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

4.2.3. Level of Education and Employment status.

Table 3 shows the distribution of the level of education and employment status of the respondents according to sex. In terms of education the results showed that 0.7 % did not answer while 2.9% had never been to school, 12.9% had reached primary school, 65% had reached secondary school and 18.6% had reached tertiary level. In terms of employment status the results showed that 25% were in formal employment, 4.3% were in informal employment, while 41.4% were in business. Respondents who were not in any form of employment or business were asked to specify other occupations they were involved in these included housewife, farmer or peer educator. 29.3% accounted for these respondents.
Table 3 Distribution of the respondent’s level of education and employment status

<table>
<thead>
<tr>
<th>Educational attainment</th>
<th>Sex</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>Never been to school</td>
<td>0</td>
<td>2.9%</td>
</tr>
<tr>
<td>Primary school</td>
<td>4.3%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Secondary school</td>
<td>36.4%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Tertiary education</td>
<td>8.6%</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

| Employment status      |          |          |
| Formal employment      | 17.9%    | 7.1%     | 25%      |
| Informal employment    | 2.1%     | 2.1%     | 4.3%     |
| Business               | 23.6%    | 17.9%    | 41.4%    |
| Others                 | 6.4%     | 22.9%    | 29.3%    |
| Total                  | 50%      | 50%      | 100%     |

4.3 Knowledge on maternal health.

To assess the level of knowledge on maternal health the respondents answered a total of 20 questions, the level of knowledge was based on the correct responses given. The results showed that majority male 49.3% and female 50% knew about maternal health while 0.7% males did not know.
4.3.1 Advantages of antenatal and postnatal care

The respondents were asked in multiple response questions to give some of the advantages of antenatal and postnatal care. The respondents showed high level of knowledge on advantages of antenatal with an average of 90.7%. The results showed that 47.1% males compared to 50% females mentioned monitoring growth of the child as an advantage while 46.4% males compared to 48.6% females mentioned knowing the health of the mother as an advantage, 47.1% males compared to 45% females mentioned detecting and preventing complications. An equal number of males 42.9% and 42.9% females mentioned understanding pregnancies while 41.4% males compared to 38.6 females mentioned planning for safe delivery and 42.1% males compared to 44.3% females mentioned promoting a healthy lifestyle.

While the respondents showed low level of knowledge on postnatal care with an average of 53.9%. The results showed respondents 22.9% males compared to 25.7% females said postnatal care increased the self-confidence of the mother while 11.4% males compared to 10.7% females said postnatal reduced post-partum depression. 42.1% males compared to 40.7% females said it increased the feelings of support and love from partner. 32.9% males compared to 36.4% females said postnatal care increased baby soothing skills while an equal number of males 40.7% and females 40.7% said postnatal prepared them for what to expect from babies and 5% males compared to 9.3% females said postnatal gave them a greater sense of communication with the infant. Figures 1 and 2 summarize these results.
Figure 1: Percentage distribution on Advantages on antenatal

Figure 2: Percentage distribution on Advantages of Postnatal
4.3.2 Tests and needs during pregnancy

The respondents were asked in another multi response question to mention the mandatory tests and needs of women during antenatal checkup in order to stay healthy. The results showed that 50% males compared to 47.9% females said that women were tested for HIV while only 18.6% males compared to 17.9% females mentioned that women were screened for Hepatitis B. 34.3% males compared to 27.9% females said that women were screened for hemoglobin, 48.6% males compared to 50% females said women were examined for blood pressure and 32.9% males compared to 35.7% females mentioned that women were examined for blood sugar. The results further showed that 15.7% males compared to 19.3% females mentioned Calcium supply while 49.3% males compared to 44.3% females mentioned Tetanus toxoid vaccination. 45% males compared to 42.9% females mentioned iron contained food and 48.6% males compared to 49.3% females mentioned folic acid. Figure 3 shows these results.
4.3.3 Prevention of mother to child.

Respondents were asked if they knew about mother to child transmission. The majority male 49.3% and female 47.1% respondents said they had heard of prevention of mother to child while 0.7% did not respond. 2.9% female respondents said they never heard of transmission of mother to child.

Further majority male 49.3% and female 47.9% respondents said women were tested during the first visit. While 2.1% females did not respond and 0.7% males said before delivery.

The respondents were asked in a multi response question to mention ways of preventing mother to child transmission of HIV. The results showed that 25% males compared to 27.1% females said provision of ARV prophylaxis to mother while 1.4% males compared to 5% females said taking herbal medicine. 42.1% males compared to 37.1% females said by taking anti-retroviral drugs and 11.4% males compared to 17.1% females said by taking pre exposure prophylaxis. The mean score was 42.5%, Figure 4 shows the results.
4.3.4 High risk pregnancies and maternal mortality.

Respondents were also able to recognize the signs and symptoms of high risk pregnancies. The results showed that 30% males compared to 32.9% females mentioned excessive vomiting while 47.9% males compared to 47.1% females mentioned vaginal bleeding. 42.1% males compared to 31.4% females mentioned fatigue, and 45.7% males compared to 42.9% females mentioned increased blood pressure. 35% males compared to 36.8% females mentioned swelling and 33.6% males compared to 22.1% females mentioned difficult labor while 17.1% males compared to 12.9% females said convulsions. The mean score for the responses was 69.2%.

Further, respondents were able to mention the causes of maternal mortality. With a mean score of 71.1% the results showed that 32.1% males compared to 25% females said age. While 47.1% males compared to 46.4% females said excessive bleeding after delivery and 47.9% males compared to 44.3% females said high blood pressure. 47.1% males compared to 36.4% females said unsafe abortion while 27.1% males compared to 19.3% females said blood clots and 30.7% males compared to 22.9% females said heart disease. Figures 5 and 6 show this information.
Respondents were also asked what had to be done when a pregnant woman showed signs and symptoms of a high risk pregnancy. The majority of male 49.3% and female 49.3% said report to health centre.
4.3.5 Deformity

The respondents were asked at what stage of pregnancy deformity was most likely to happen. The results in Figure 7 show that 11.4% males compared to 12.9% females said that it took place at 12 weeks, while 28.6% males compared to 27.9% females said it took place between 12 and 28 weeks, 2.9% males compared to 2.1% females said it took place above 28 weeks and 5% males compared to 5.7 females said it depended with the pregnancy and did not specify when. 3.6% of the respondents did not respond.

![Figure 7: Percentage distribution on Deformity](image)

4.3.6 Awareness

The study revealed that more males 45.7% than females 30.7% were aware that infection during pregnancy could harm the baby. In addition more males 48.6% than females 40.7% were aware that proper nutrition for a pregnant woman prevented fetal abnormalities. The study also revealed that more males 50% than females 47.1% were aware that medicines other than those prescribed by the doctor could harm the baby. While less males 34.3% than females 35.7% were aware that a sterilized thread was used to cut the cord. However, more males 49.3% than females 48.6% were aware that a child had to be taken for vaccination and more males 47.9% than females 45.7% used oral rehydration therapy when a child had diarrhea. Table 4 summarizes these findings.
<table>
<thead>
<tr>
<th></th>
<th>Sex</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>Infection during pregnancy</td>
<td>45.7%</td>
<td>30.7%</td>
</tr>
<tr>
<td>Proper Nutrition</td>
<td>48.6%</td>
<td>40.7%</td>
</tr>
<tr>
<td>Prescribe medicine</td>
<td>50%</td>
<td>47.1%</td>
</tr>
<tr>
<td>Sterilized thread</td>
<td>34.3%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Vaccination</td>
<td>49.3%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Oral rehydration therapy</td>
<td>47.9%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Total</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Respondents were asked when a child should be weaned. The results showed that more males 22.9% than females 20.7% said after 6 months and more males 15% than females 6.4% said after 12 months. While fewer males 7.9% than females 12.9% said children should be weaned after 18 months and fewer males 4.3% than females 10% specified to say children should be weaned after 24 months. Figure 8 shows responses according to sex.
4.4 Gender norms towards male involvement

The questionnaire was also designed to assess the gender norms towards male involvement in maternal health. The respondents were given statements which they had to either agree or disagree with. A norm about attending antenatal being exclusively for women revealed that more males 17.9% than females 15.7% indicated agree, while 32.1% males and 34.3% females indicated disagree. Another norm about a man accompanying his wife/partner to the delivery room/labor ward revealed that more males 16.4% than females 15.7% indicated agree while 32.9% males and 34.3% females indicated disagree. These findings were relating with the findings from the in-depth interviews. Female respondents did not agree with men being present in the delivery room because of cultural beliefs. One respondent said:

"Some say when a man sees blood they get perplexed and say they have seen a vagina so they can’t sleep with the wife and he would not respect the wife. It’s a taboo for men to be present looking at the pain which women undergo they can think maybe they should stop having babies. Some would say the man has been charmed, why is he going there he is under pit coat government.” Female respondent.

Another respondent affirmed this statement by saying:
They think that if men see your blood it will affect the way he looks at you, he will not respect you or have sexual intercourse with you when he sees you giving birth. Because of such beliefs my husband does not attempt to escort me to the labor ward instead he calls my sisters to come and wait for me”. Female respondent.

A norm about a man helping out with household chores when a woman was pregnant revealed that more males 45% than females 44.3% indicated agree while 5% males and 5.7% females indicated disagree. In-depth interviews suggested a number of reasons for men to help out with household chores. One of the reasons which came out eminently was that men should help out with household chores so that their wives could rest. One respondent said:

“I think men should attend to women when there is need because babies are a lot of work. I help with the cooking and cleaning of the house. So that my wife can rest and focus on the baby. Sometimes as she is resting I help with the baby and put the baby to sleep sometimes I change the baby’s nappy.” Male respondent

A female respondent also agreed with this statement by saying:

He helps clean the house and fetch water and also what is needed to be done at home. Sometimes he helps wash even with his own clothes and help with house chores. He even buys me food that I crave for as long as I tell him in advance as he is about to leave the house”. Female respondent.

However, a norm about a man helping out with sterilizing the cord showed that 10.7% males and 18.6% females indicated agree while more males 39.3% than females 31.4% indicated disagree. A respondent during an In-depth interview agreed with these findings. Most men agreed that they could help out with household chores but declined to help cleaning the baby because they did not have the experience and did not want to cause harm to the baby. One respondent said:

There is nothing wrong with men attending to women as it is their job. I can only dispute when it comes to cleaning our new born baby because I do not have the experience. Otherwise were I can if I am able to do then I will do. I clean the house when my wife is unwell. I prepare the food and sometimes bath her. When it comes to our child I sometimes bath the baby.” Male respondent.
Another respondent during in-depth interviews said:

“There is nothing wrong with men attending to women. Once in a while I will help clean the baby and feed the baby when the baby is a few months old. After my wife delivers I would clean the house and cook so that the only job my wife does is bath herself and the baby because the baby is fragile and small I can break his bones.” Male respondent.

Another norm about men as financial providers affecting the level of involvement showed that more males 22.9% than females 22.1% indicated agree and 27.1% males and 27.9% females indicated disagree. However these results were not relating with the in-depth interview results as respondents said men’s roles were to provide money so they did not have time to be involved in maternal health. One respondent said

“A man cannot go to the antenatal because men’s roles are to provide money. It is just that men are sometimes busy. Sometimes men who support their wives are suspected of being charmed by their wives, this makes some men become less involved in their wives’ pregnancies while some men continue being involved” female respondent.

Another female respondent said:

“Some men are too busy they go in the morning and come back in the evening. They do not have time to stay home and learn about the pregnancy or ask how your day was “Female respondent.

In addition a norm on the role of women as mothers and caregivers affecting male involvement in postnatal care revealed that more males 20.7% than females 17.1% indicated agree while 29.3% males and 32.9% females indicated disagree. However, a norm on men taking their child for immunization indicated that more males 45.7% than females 40.7% indicated agree while 4.3% males and 7.9% females indicated disagree. These results were backed up with the results from the in-depth interviews. A female respondent said:

“My husband used to go with me to the clinic he would carry the baby along the way and pay for transport or any bills at the hospital” Female respondent.
Table 5 summarizes this information.

**Table 5: Percentage of respondents opinion on gender norms**

<table>
<thead>
<tr>
<th>Norm</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>Antenatal exclusively for women</td>
<td>17.9%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Escorting wife to the labor ward</td>
<td>16.4%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Helping wife with household chores</td>
<td>45%</td>
<td>44.3%</td>
</tr>
<tr>
<td>Help with sterilizing the cord and cleaning the baby</td>
<td>10.7%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Men as financial providers affects involvement</td>
<td>22.9%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Women as mothers and care givers affects involvement</td>
<td>20.7%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Men and women should take children for immunization</td>
<td>45.7%</td>
<td>40.7%</td>
</tr>
</tbody>
</table>
4.5 Attitudes towards male involvement

To assess the attitude towards male involvement respondents were given statements which they had to either agree with or disagree with. Respondents were asked if a man should accompany his partner for antenatal clinic the results revealed that more males 48.6% than females 47.9% indicated agree while 1.4% males and 2.1% females indicated disagree.

In order to assess the attitude of the respondents towards family planning respondents were asked whether men should encourage family planning. The results showed that more males 47.9% than females 45.9% indicated agree while 2.1% males and 4.3% females indicated disagree. Further when asked if family planning encouraged promiscuity the results showed that fewer males 16.4% than females 18.6% indicated agree while 33.6% males and 30.7% females indicated disagree.

However, when asked if a man should attend antenatal and postnatal clinic with his partner the results revealed that fewer males 41.4% than females 43.6% indicated agree while 8.6% males and 6.4% females indicated disagree.

Respondents were further asked if men should provide finances for antenatal care. The results showed that fewer males 47.9% than females 48.6% indicated agree while 2.1% males and 1.4% females indicated disagree. In addition respondents were asked if men should provide finances for transport to the health facility during delivery the results showed that an equal number of males 47.9 and females 47.9% indicated agree and an equal number of males 2.1% and females 2.1% indicated disagree.

Respondents were given another statement asking if husbands should offer assistance during pregnancy and childcare. The results showed that an equal number of males 48.6% and females 48.6% indicated agree and an equal number of males 1.4% and females 1.4% indicated disagree. However, when asked if a pregnant woman should change dietary habits as advised by the doctor the results showed that more males 50% than females 49.3% indicated agree while no respondent indicated disagree. Table 6 illustrates this information.
Table 6: Percentage of respondent’s attitudes towards male involvement

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>A man should accompany his partner to the antenatal clinic</td>
<td>48.6%</td>
<td>47.9%</td>
</tr>
<tr>
<td>Men should encourage family planning</td>
<td>47.9%</td>
<td>45.7%</td>
</tr>
<tr>
<td>family planning encourages promiscuity</td>
<td>16.4%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Husbands should attend antenatal and postnatal with their partner</td>
<td>41.4%</td>
<td>43.6%</td>
</tr>
<tr>
<td>Men should provide finances for antenatal</td>
<td>47.9%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Men should provide transport to the health facility during delivery</td>
<td>47.9%</td>
<td>47.9%</td>
</tr>
<tr>
<td>Husbands should offer assistance during pregnancy and childcare</td>
<td>48.6%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Pregnant women should change dietary habits as advised by the doctor</td>
<td>50%</td>
<td>49.3%</td>
</tr>
</tbody>
</table>
4.6. Involvement in maternal health

In order to assess the involvement of men during and after pregnancy respondents were asked questions on their involvement during family planning, antenatal, delivery and postnatal care.

4.6.1 Involvement during family planning

The study revealed that more males 46.4% than females 37.9% participated in family planning discussions with their partners. In addition more males 25% than females 24.3% participated in family planning discussions as couples with a family planning counselor. More males 36.3% than females 35% were involved as couples in picking the family planning method to use and more males 23.6% than females 20.7% sought help as couples when family planning effects occurred. These results relate with the results from the in-depth interviews as a respondent said he was interested in matters of family planning and sexually transmitted diseases.

“Matters of family planning and sexually transmitted diseases, these are some of the trending diseases amongst couples. I participate by frequenting the clinic with my wife to find out which method we can best use in our state and how to space our children so that we stay healthy and maintain our status as a couple.” Male respondent.

Table 7 illustrates this information.

<table>
<thead>
<tr>
<th>Type of Involvement</th>
<th>Sex</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>Family planning discussion with partner</td>
<td>46.4%</td>
<td>37.9%</td>
</tr>
<tr>
<td>Couple discussion with family planning counselor</td>
<td>25%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Pick family planning method as couples</td>
<td>36.3%</td>
<td>35%</td>
</tr>
<tr>
<td>Seek for help as couples when effects occur</td>
<td>23.6%</td>
<td>20.7%</td>
</tr>
</tbody>
</table>
4.6.2 Involvement during Antenatal

The study revealed that more males 35% than females 33.6% attended antenatal care with their partners. Also more males 47.1% than females 35.7% provided money for antenatal and postnatal care. Further, more males 47.9% than females 33.6% provided money for skilled birth at a hospital and more males 48.6% than females 35.7% paid for transport and necessary supplies ahead of time.

To confirm these findings male respondents during in-depth interviews described their experiences when they first visited the antenatal clinic. One male respondent said:

“When we got to the clinic the nurse was entering names in the register for the new comers. They took down the details and asked us a few questions about our life style in case there was anything important to note. We then waited as the nurses where giving lessons about pregnancy, the danger signs of pregnancy and breastfeeding. This was helpful for us because we did not know all this and if I didn’t follow I would not have known. They then measured my wife’s BP and weight and we went for counselling, they counselled us and told us it was important we get tested. They drew the blood and tested us. After being given the results they asked my wife when she had her last period and they calculated her due date and tested her for other infections and gave her some red pills before giving us an appointment for the following month” male respondent.

Table 8 illustrates this information

Table 8: Percentage of respondent’s involvement during antenatal

<table>
<thead>
<tr>
<th>Type of involvement</th>
<th>Sex</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>Attend antenatal clinic with partner</td>
<td>35%</td>
<td>33.6%</td>
</tr>
<tr>
<td>Provide money for antenatal and postnatal care</td>
<td>47.1%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Provide money for skilled birth</td>
<td>47.9%</td>
<td>33.6%</td>
</tr>
<tr>
<td>Pay for transport and supplies ahead of time</td>
<td>48.6%</td>
<td>35.7%</td>
</tr>
</tbody>
</table>
4.6.3 Involvement during pregnancy and after

The study showed that fewer males 5.7% than females 7.1% were involved during pregnancy by being present in the delivery ward. However, more males 25.7% than females 18.6% said husbands helped cleaning and feeding the baby. And more males 25.7% than females 20.7% were involved in discussions on postpartum complications as couples. In addition more males 42.1% than females 32.1% were involved as couples in making sure the children were completely immunized. More males 37.1% than females 32.9% were involved as couples in taking children for under 5. Table 9 summarizes this information.

Table 9: Percentage of respondent’s involvement during and after pregnancy

<table>
<thead>
<tr>
<th>Type of involvement</th>
<th>Sex</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>Support during delivery (presence labor ward)</td>
<td>5.7%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Husbands helping out with cleaning and feeding the baby</td>
<td>25.7%</td>
<td>18.6%</td>
</tr>
<tr>
<td>Discuss postpartum complications as couples</td>
<td>25.7%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Making sure children are immunized</td>
<td>42.1%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Taking children as couples for under 5</td>
<td>37.1%</td>
<td>32.9%</td>
</tr>
</tbody>
</table>

The study further revealed that an equal number of males 1.4% and females 1.4% visited the clinic as couples every week while more males 13.6% than females 12.9% visited the clinic as couples every month and more males 10% than females 7.9% visited the clinic as couples every three months. More males 23.6% than females 20.7% visited the clinic as couples during the first visit. Figure 9 shows these results.
Figure 9: Percentage of responses on antenatal visits

4.7 Perception towards male involvement

In order to identify the respondents’ perception towards male involvement in maternal health, the respondents were given statements which they had to either agree with or disagree with. Respondents were asked if pregnancy should be a shared responsibility between couples the results revealed that an equal number of males 46.4% and females 46.4% indicated agree while 2.9% males and 3.6% females indicated disagree. Further when asked if a pregnant woman needed care and support during pregnancy and after delivery the results showed that more males 50% than females 49.3% indicated agree while 0.7% females indicated disagree.

These results correspond with the results from the in-depth interviews as many respondents agreed to having supported their wives. One respondent said:

"I help my wife clean the house and cook the food when she is not feeling well. Sometimes I bath her and massage her feet when they swell. When the baby is born I clean the house so that my wife’s only job is to breastfeed the baby. When I come back from work I help the baby stop crying as my wife is cooking. When it is vaccination week I give my wife enough money for transport and any expenses as I go for work." Male respondent.
Another respondent also agreed to say her husband supports her and she described the type of support she received by saying:

“He helps clean the house and fetch water and also what is needed to be done at home. Sometimes he helps even with washing clothes including his own clothes. He even buys me food that I crave for as long as I tell him in advance as he is about to leave the house”. Female respondent.

In addition respondents were asked if husbands should discuss their partners pregnancy with a health care provider, the results showed that more males 32.9% than females 25% indicated agree while 16.4% males and 17.9% females indicated disagree. However, when asked if men should be present in the delivery room the results showed that an equal number of males 6.4% and females 6.4% indicated agree while an equal number of males 43.6% and females 43.6% indicated disagree. These results correspond with the results from the in-depth interviews as respondents described the type of experience they had with hospitals. One respondent said:

“During delivery the nurses are mean they do not even allow us to go anywhere near our wives especially the ward, men are not allowed so we do not even attempt because they are a lot of women in the ward. Even I would feel uncomfortable looking at another woman’s nakedness”. Male respondent.

Table 10 illustrates these findings.
Table 10 Distribution of respondent’s perception towards male involvement

<table>
<thead>
<tr>
<th>Perception</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>Pregnancy a shared responsibility between couples</td>
<td>46.4%</td>
<td>46.4%</td>
</tr>
<tr>
<td>Pregnant women need care and support during pregnancy and after delivery.</td>
<td>50%</td>
<td>49.3%</td>
</tr>
<tr>
<td>Discuss pregnancy with a health care provider</td>
<td>32.9%</td>
<td>25%</td>
</tr>
<tr>
<td>Men should be present in the delivery room</td>
<td>6.4%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

4.8 Factors associated with attitudes and perception towards male involvement in maternal health

The Pearson Chi square was used to test for association between variables. The independent variables in this study included marital status, education and employment status.

4.8.1 Relationship between marital status and maternal health

With a p value of 0.03 there was an association between marital status and knowledge on maternal health. This indicated that these observations are statistically significant. However, there was no association between marital status and attitude towards accompanying partner for antenatal clinic with a p value of 0.29. Nevertheless there was an association between marital status and involvement in family planning discussions with a p value of 0.001. This indicated that the observations are highly significant. There was no association between marital status and involvement in attending antenatal clinics together with a p value of 0.507. Nevertheless there
was an association between marital status and involvement in making sure the children were completely immunized with a p value of 0.001. However, there was no association between marital status and perception of pregnancy being a shared responsibility with a p value of 0.579. Table 11 summarizes these results.

Table 11: Relationship between Marital status and maternal health

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Married (%)</th>
<th>Unmarried (%)</th>
<th>Pearson chi square</th>
<th>Df</th>
<th>Sig (2 sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge on maternal health</td>
<td>82.1%</td>
<td>17.9%</td>
<td>4.633</td>
<td>1</td>
<td>0.031</td>
</tr>
<tr>
<td>Attitude towards men accompanying their spouse to antenatal</td>
<td>82.1%</td>
<td>17.9%</td>
<td>1.127</td>
<td>1</td>
<td>0.288</td>
</tr>
<tr>
<td>Involvement in family planning discussions</td>
<td>77.8%</td>
<td>16.5%</td>
<td>23.903</td>
<td>1</td>
<td>0.001</td>
</tr>
<tr>
<td>Involvement in attending antenatal clinic with partner</td>
<td>77.1%</td>
<td>15.8%</td>
<td>0.440</td>
<td>1</td>
<td>0.507</td>
</tr>
<tr>
<td>Involvement in making sure children are completely immunized</td>
<td>75.7%</td>
<td>15%</td>
<td>32.539</td>
<td>1</td>
<td>0.001</td>
</tr>
<tr>
<td>Perception that pregnancy is a shared responsibility</td>
<td>81.4%</td>
<td>17.9%</td>
<td>0.308</td>
<td>1</td>
<td>0.579</td>
</tr>
</tbody>
</table>

4.8.2 Relationship between Educational attainment and maternal health

With a p value of 0.694 there was no relationship between education and knowledge in maternal health. This indicated that these observations were statistically insignificant. Further the test revealed that there was no relationship between education and attitude towards accompanying partner for antenatal clinic with a p value of 0.795. There was also no relationship between education and involvement in family planning discussions with a p value of 0.498. In addition
there was no relationship between education and involvement in attending antenatal clinics as couples with a p value of 0.108. With a p value of 0.681 there was no relationship between education and involvement in making sure children are completely immunized. And there was no relationship between education and the perception towards pregnancy being a shared responsibility with a p value of 0.595. Table 12 summarizes these results.

**Table 12: Relationship between Education and Maternal health**

<table>
<thead>
<tr>
<th></th>
<th>Education</th>
<th>Pearson chi square</th>
<th>Df</th>
<th>Sig (2 sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Educated (%)</td>
<td>No or lower level of Education (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge on maternal health</td>
<td>83.6%</td>
<td>15.8%</td>
<td>0.155</td>
<td>1</td>
</tr>
<tr>
<td>Attitude towards men accompanying their spouse to antenatal</td>
<td>83.6%</td>
<td>15.8%</td>
<td>0.068</td>
<td>1</td>
</tr>
<tr>
<td>Involvement in family planning discussions</td>
<td>79.3%</td>
<td>14.4%</td>
<td>0.460</td>
<td>1</td>
</tr>
<tr>
<td>Involvement in attending antenatal clinic with partner</td>
<td>77.9%</td>
<td>14.4%</td>
<td>2.585</td>
<td>1</td>
</tr>
<tr>
<td>Involvement in making sure children are completely immunized</td>
<td>75.8%</td>
<td>14.4%</td>
<td>0.169</td>
<td>1</td>
</tr>
<tr>
<td>Perception that pregnancy is a shared responsibility</td>
<td>82.9%</td>
<td>15.8%</td>
<td>0.283</td>
<td>1</td>
</tr>
</tbody>
</table>

### 4.8.3 Relationship between Employment status and maternal health

The test revealed that there was no relationship between employment status and knowledge in maternal health with a p value of 0.082. There was also no relationship between employment
status and the attitude towards accompanying partners for antenatal clinic with a p value of 0.189. With a p value of 0.082 there was no statistically significant relationship between employment status and involvement in family planning discussions with partners. Further there was no relationship between employment status and involvement in attending antenatal clinic as couples with a p value of 0.604. With a p value of 0.338 there was no significant relationship between employment status and involvement in making sure children are completely immunized. And there was no relationship between employment status and the perception that pregnancy should be a shared responsibility with a p value of 0.833. Table 13 summarizes this information.

**Table 13: Relationship between Employment status and maternal health**

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Formal Employment (%)</th>
<th>Informal Employment (%)</th>
<th>Pearson chi square</th>
<th>Df</th>
<th>Sig (2 sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge on maternal health</td>
<td>25%</td>
<td>75%</td>
<td>3.022</td>
<td>1</td>
<td>0.082</td>
</tr>
<tr>
<td>Attitude towards men accompanying their spouse to antenatal</td>
<td>25%</td>
<td>75%</td>
<td>1.728</td>
<td>1</td>
<td>0.189</td>
</tr>
<tr>
<td>Involvement in family planning discussions</td>
<td>25%</td>
<td>69.3%</td>
<td>3.016</td>
<td>1</td>
<td>0.082</td>
</tr>
<tr>
<td>Involvement in attending antenatal clinic with partner</td>
<td>25%</td>
<td>61.7%</td>
<td>0.270</td>
<td>1</td>
<td>0.604</td>
</tr>
<tr>
<td>Involvement in making sure children are completely immunized</td>
<td>24.3%</td>
<td>62%</td>
<td>0.919</td>
<td>1</td>
<td>0.338</td>
</tr>
<tr>
<td>Perception that pregnancy is a shared responsibility</td>
<td>25%</td>
<td>74.3%</td>
<td>0.045</td>
<td>1</td>
<td>0.833</td>
</tr>
</tbody>
</table>
4.9 Strategies to improve male involvement

Respondents through in-depth were asked to provide strategies, the aim was to make recommendations for strengthening involvement among men in maternal health. The respondents agreed that men desired to be involved but there was no motivation and agenda for men because all that they did when they visited the hospital was to wait around for their wives to be done as the focus was on women.

One of the strategies brought forth by the respondents was that hospitals needed to make bigger spaces that would accommodate men attending antenatal care as they were mostly told to wait outside and only go in during their wives’ medical examinations. This would motivate men to attend antenatal clinics as they would have somewhere to sit comfortably while attending the clinic. Additionally respondents suggested that hospitals needed to initiate programs that targeted men because the only role men played when they went for antenatal was get tested for HIV. One respondent said:

“They should build bigger spaces to accommodate men too and prepare messages on how men should be involved other than just being tested for HIV and paying bills.” Male respondent.

Another respondent agreed with this statement by saying:

“Men need to be sensitized more and the clinic needs to make programs targeting men and the space should be accommodating because most men fear standing outside when they go for antenatal because the space is too small.” Male respondent

The interviewed respondents also suggested that health facilities should extend the service to the weekend so that men who were busy during the week could have time to attend during the weekend. This would allow men to attend antenatal care with their wives and get counselled and taught together. Further the service should be extended to the communities as most men were financial providers and had no free time to attend antenatal clinic. This would help men who were unable to go to the health facility due to work demands have time to learn from the
community. Health workers should go in the communities and sensitize men on the importance of male involvement. One respondent said:

“Men should be encouraged by telling them the benefits of male involvement and by extending the service to the community through sensitization.” Male respondent

Another respondent agreed with this statement by saying:

“Men are already being encouraged by giving quick and fast service to women who attend antenatal with their husbands. What they can do is also extend the service to over the weekend so that more men who are busy during the week can attend with their spouses.” Male respondent.

One respondent also suggested that men should be allowed in the delivery room. As they were not allowed to enter the delivery room because it was considered a woman’s domain. This made men feel as though they were not part of the pregnancy and they did not know what women went through. Women also felt alone in the delivery room without support from their husbands during the delivery period. One respondent said:

“Men should be allowed to be with their wives during delivery this would encourage them as they would feel part of the process and they would love their wives more as they would see what women go through. The hospital should come up with talks specifically targeting men.” Male respondent.
CHAPTER 5

DISCUSSION OF FINDINGS

5.1 Introduction.

In this chapter, the discussion of these findings will contribute to the understanding of the situation concerning gender norms, attitudes and perceptions towards male involvement in maternal health in Kafue. This discussion will be based on the research objectives as an attempt to answer the key research questions. It will also seek to establish commonalities between views of the different informants which in turn will serve as a means of validating the findings of the study. The main focus of the study was to investigate the gender norms, attitudes and perceptions towards male involvement in maternal health in Kafue district. The study also sought to assess the level of knowledge in maternal health among men and women, examine the gender norms, attitude and perceptions of men and women in maternal health and finally to assess socio economic and demographic factors that may be associated with attitudes, involvement and perceptions of male involvement in maternal health.

5.2 Social demographic background of the respondents.

Results from the study showed that majority (46.4%) of the respondents were between the ages 31-45 and a few (9.3%) were between the ages 16-30. According to the Zambia Demographic and Health Survey (ZDHS) report it proposes that overall, among women aged between 20-49 those who reside in urban areas marry two years later than their counterparts in rural areas (20 and 18 years respectively) (CSO et al., 2007). This average is normal in communities where strong significance is attached to higher education for both sexes. Engagement in educational activities affects age at marriage, increase an individual’s occupational opportunities and income.

Out of the 150 respondents interviewed 75 were male and 75 were female. Majority of the respondents were married, had been to secondary school and were in business. This finding is similar to that of Tshibumbu 2006, were he found that education level of men was a significant factor that influences men’s participation in PMTCT services.
According to Dhakal et al. (2007) the husband's occupation may represent family income as well as social status. Some men may have the knowledge and positive attitude towards maternal health care yet their work demands them to work throughout the day. This may mean no extra time for them to attend maternal health clinics though they may encourage their partners to attend (Dhakal et al, 2007).

5.3 Level of knowledge in maternal health among men and women

The study revealed that majority of the respondents knew about antenatal care. With an average of 90.7% response more females than males were able to identify advantages of antenatal care which indicated a high level of knowledge on antenatal care among women. Further, more females than males were able to mention the advantages of postnatal care. However the response rate among female and male respondents was low on postnatal care. This suggested that respondents attended antenatal care with partners more than they attended postnatal care with partners. This disparity could be attributed to the occupation of the husband and health policy to impose compulsory couple screening during first antenatal booking in all health centers.

These results correlate with the results found in a study done in Gulu district which revealed that 48% of the males accompanied wives during postnatal care services and 65.4% during antenatal care services (Twehiyo, 2009). However these findings were a lot higher than the results found in northern Tanzania where male involvement was reported to be only 12.5% (Msuya et al; 2008).

The study also revealed that more male respondents than female respondents were able to identify the tests and needs of a pregnant woman during antenatal in order to stay healthy. This contradicts the study done by Mullany (2005) on Barriers to and attitudes towards promoting husbands' involvement in maternal health in Katmandu, Nepal, where most men had low levels of knowledge which was found to be one of the most prominent barriers to male involvement in maternal health. Further, more males than females admitted to having heard about prevention of mother to child and more males than females said it was conducted during the first visit of antenatal. However, more female than male respondents were able to identify appropriate ways of preventing mother to child transmission. These findings suggest that an increase in knowledge about PMTCT may have a positive association to male involvement. These findings are
consistent with the finding from a study done in Tanzania that indicated that lack of knowledge on PMTCT was a deterrent to men’s involvement in PMTCT, (Theuring et al, 2009).

The study further discovered that respondents were knowledgeable about the signs and symptoms of high risk pregnancies and knew what needed to be done when a pregnant woman showed these signs. The results showed that more males than females were able to identify some of the signs and symptoms of high risk pregnancy while more females than males were able to identify some signs and symptoms of high risk pregnancies. Though majority males and females knew what needed to be done when a woman exhibited such symptoms. Furthermore, more males than females were able identify the major causes of maternal mortality. This suggests that an increase in the level of education had a positive influence on men’s involvement. This finding was similar to that of Tshibumbu 2006, were he found that education level of men was a significant factor that influenced men’s participation in PMTCT services. According to Dhakal et al (2007) men who have attained higher level of education were likely to be more knowledgeable on maternal health care and as such more likely to influence their partners to seek the service than men with no or lower level of education. The husband’s education could represent family income and social status (Dhakal et al, 2007).

Nwonkocha (2008) in his study found similar results were a woman’s level of education was related to her ability to recognize symptoms of pregnancy associated complications, healthy nutrition during pregnancy and how and when to use contraceptives to control fertility (Nwonkocha, 2008).

Respondents were also able to say when deformity of a new born was likely to take place majority of male and female respondents said deformity of a newborn was most likely to happen at 12 to 28 weeks. Whereas, more males than females admitted that infection during pregnancy could harm the baby and more males than females were convinced that proper nutrition for a pregnant woman prevented fetal abnormalities.

The study further revealed that more males than females were aware that medicines other those prescribed by the doctor could cause harm to the baby. However, more females than males were aware that a sterilized thread was used to cut and tie the cord. This was attributed to the fact that men were not taught issues related to labor and delivery. This information was exclusively given
to women. More males than females agreed that a child should be taken for immunization. And more males than females admitted to having used oral rehydration therapy whenever a child had diarrhea.

However, there was a variation in response when asked at what stage a child should be weaned. The majority of male and female respondents agreed it was after 6 months but further added that the clinic advised children should be breastfed for up to 24 months. The mother had the final decision of when to wean the baby.

Generally in terms of knowledge, the study revealed that more men than women were knowledgeable on maternal health except when it was relating to delivery and child care, this was because such information was withheld from men. This contradicts the study done by Mullany (2005) on Barriers to and attitudes towards promoting husbands' involvement in maternal health in Katmandu, Nepal, where most men had low levels of knowledge which was found to be one of the most prominent barriers to male involvement in maternal health.

5.4 Gender norms towards male involvement.

The findings in this study discovered that most men were interested in maternal health care. This was evident by the number of female and male respondents who did not agree that attending antenatal clinic was exclusively for women. However, the entrenched gendered perception of maternal health care services being for women only was reflected in the design of infrastructure for maternal health services. These results did not correspond with the results found by Nwokocha, 2008 in his study maternal crisis and the role of African men, were he discovered that women were socialized to perceive male dominance as normal to the extent that supernatural connotations were further employed to intensify the acclaimed inevitability of patriarchy. Over dependence on men on matters that directly affected women and for which the latter had privileged knowledge could have devastating effects on them and their entire families. However, he suggested that enhancing the role of men during maternal processes was a critical factor in ensuring that pregnancies were less vulnerable to mishaps (Nwokocha, 2008).

Another school of thought argues that male involvement in this traditionally female domain could sometimes deter women from receiving appropriate maternal health care in households
where decision making was in the hands of men (Ormel, 1999). This was because traditionally accessing maternal health care lies predominantly in the female domain. It is very likely that men often do not have access to medical practitioners who offer maternal health care services. Even if men were interested in getting involved in their wives maternal health, it was often elder female members of the household who dominated in women’s access to maternal health care (Barua et al, 2004).

Majority male and female respondents did not agree with the statement “men should accompany their wives to the labor ward.” Although, male midwives attend to women during maternal health services in health facilities, that did not change the perception of the community that a labor companion always had to be a woman. These findings concur with the assumptions made by Moser (1993) that reproductive work is almost always the responsibility of women and girls.

This finding was supported by results from in-depth interviews where respondents feared cultural beliefs and norms such as “if a man saw a woman giving birth it will affect the way he looks at her, he would not respect her or have sexual intercourse with her when he sees her giving birth.” As a result women stop men from going near the labor ward. Likewise men feared seeing other women’s nakedness as it was a taboo. Osborne 2014, in his study attitudes of rural communities towards male midwives found similar findings; he concluded that health facilities did not provide privacy for clients. As a result of such lack of privacy, laboring women were only allowed to have a female labor companion in the labor ward the system which was not in favor of male involvement (Osborne, 2014). Hence most of the respondents did not agree with men being present in the labor ward.

Gendered belief systems foster assumptions about appropriate behavior for men and women and may have an effect on the type of work women and men perform. Grimshaw (1986), for instance, pointed out that motherhood has often been ideologically constructed in ways that have served to legitimize the dependence of women on men. Her position that motherhood annihilates women and should therefore for some time be totally rejected as it re-echoes the position of most feminists that being a mother not only destroys one’s freedom but also a means to submit to patriarchy. But going by the African value that places premium on children, the emphasized limitation of motherhood is clearly contradictory. Moreover, the status of women in most
societies in Africa is confirmed by their fertility and especially in having male children (Grimshaw, 1986, Nwokocha, 2007).

However, more male than female respondents agreed that men should help out with household chores when a woman is pregnant. These results were corresponding with the results from the in-depth interviews as most men described how they helped their partners during pregnancy. One male respondent agreed that “men should attend to women when there is need because babies are a lot of work. I help with the cooking and cleaning of the house so that my wife can rest”.

These findings contradict the findings from a study by Kululanga et al, 2012 where men were characterized as resource providers for the family including health care. The man is restricted to accompanying the wife to the hospital. He may take her on a bicycle so as to avoid delay and the woman giving birth along the way. Further the man was to inform the woman’s relatives that the wife was in labor and organize for a female guardian (Kululanga et al, 2012).

Further, more male than female respondents did not agree with men helping out with sterilizing and cleaning the baby. This was backed by results from the in-depth interviews as male respondents said they could not help out with cleaning of the baby as they did not possess the skills, knowledge and babies were fragile.

Similar findings have been documented by Mullick et al (2005), the social context exhibited a culture of silence around pregnancy and childbirth issues. Men were not taught issues related to labor and delivery. This information was given to women only. Men were told how to provide emotional, material and financial support to their pregnant spouses. Gender values and norms in the study area acted to ensure that labor and childbirth knowledge was withheld from men. Similar findings were also documented by Onyango et al., 2010 in Kenya.

Slightly more females than males did not agree with the statements “men as financial providers affected the level of male involvement and women as mothers and care givers affected male involvement in postnatal care”. However, these findings did not relate with the findings from the in-depth interviews as many respondents agreed that men’s roles were to provide for the family by working, one female respondent said “a man cannot go to the antenatal because men’s roles are to provide money. It is just that men are sometimes busy some men who support their wives are suspected of being charmed by their wives, this makes some men become less involved in
their wives””. Muulongo 2015, in his study found similar results men understood the roles they had to play when their wives were pregnant. However, to some men, the roles did not include attending antenatal care at the clinic. Furthermore, men stated that it was against their culture to be involved in female affairs (Muulongo, 2015, Matongo, 2014).

Regardless more male than female respondents agreed that they took their children for immunization. These findings were consistent with the results from the in-depth interview as respondents agreed that they accompanied their partners to the clinic for child immunization. However other studies dispute this finding as many discovered that due to time constraints, such as balancing the need to provide for the family versus attendance to postnatal clinic and negotiating time off from work, is a barrier to male involvement. This builds upon findings from other studies that identified socioeconomic demands, poverty and job responsibilities as a barrier to male involvement, (Mullany, 2006, Nkuoh, 2010 and Byamugisha et al, 2010).

5.5 Attitudes towards male involvement in maternal health.

Traditionally, men are believed to be decision makers, hence influence the health care seeking behavior for the whole family. However, with greater emphasis on male involvement in sexual and reproductive health, this notion is slowly fading out. For example in this study, majority male and female respondents demonstrated a positive attitude towards maternal health by accompanying their partner/spouse for antenatal clinic. Further, more male than female respondents encouraged family planning. Similar results by Odimegwu et al. (2005) reported a high level of awareness and participation of men in maternity care in Osun State.

The study further revealed that majority of male and female respondents did not agree with the statement that family planning encouraged promiscuity. This indicated a positive attitude towards male involvement as more males were in support of family planning.

These findings are similar to what Mullany (2005) found in her study on barriers to and attitudes towards promoting husbands’ involvement in maternal health, were respondents expressed favorable attitudes towards having husbands involved in pregnancy health, particularly in antenatal health care and family planning. Numerous respondents referred to how communication about health between spouses could be improved if the husband was included in
antenatal health care education (Mullany, 2005). These findings are similar to previous studies on male participation in reproductive health in Ghana (Berer, 1996; Helzner, 1996; Male Participation in Reproductive Health, 1998).

Further respondents showed a positive attitude towards husbands attending antenatal and postnatal care with spouse. This was accounted for by more female than male respondents. These findings are similar to what Lungu, (2012) discovered in her study determining knowledge, attitude and practice of men towards postnatal care services in Mazabuka were most of the respondents, admitted the importance of boys and men learning about reproductive health and maternal health and the benefits that go with it (Lungu, 2012).

The study also discovered that respondents still restricted men’s roles during pregnancy to providing finances for antenatal care and finances for transport to the health facility during delivery. This accounted for majority of both male and female respondents. Dumbaugh et al, 2012 discovered similar findings as participants in the study described an ideal father as someone who cared, provided emotional and financial support. Men had a limited role during childbirth, beyond financial and emotional support. Participants were unanimous that there needed to be education for men to increase their knowledge of pregnancy and childbirth and what transpires (Kaye et al, 2014).

Further majority male and female respondents agreed that husbands should offer assistance during pregnancy and child care. This indicated a positive attitude from the respondents as men’s involvement during pregnancy and childbirth played a vital role in the safety of their female partners’ pregnancy and childbirth, by ensuring access to care and provision of emotional and financial support. Kaye et al (2014) in their study pregnancy and child birth agrees with these findings.

In addition majority of male and female respondents showed a positive attitude towards women changing their dietary habits as advised by the doctor. Generally, these findings indicate a positive attitude towards male involvement in maternal health. The results could be attributed to the current Government policies such as the Zambia Reproductive Health Policy (2005), in which male involvement is emphasized. This was adopted at the International Conference on Population and Development of 1994 which emphasized on male involvement in maternity
though this has mostly been pronounced in antenatal care. Awareness programs on male involvement in reproductive health have been created following the notion that opportunities have to be offered to involve men in all aspects of sexual reproductive health (ZRHP, 2005). These interventions show how the precede and proceed model by Greene (1999) works and brings about behavioral change among men making them actively involved in maternal health.

This could be a possible contributor to men's understanding of the effects of maternal health to their families such as loss of their loved ones (women and neonates) and hence the zeal to be involved in every way possible.

However, this is contrary to the findings of Roudsari et al (2003) in their study; Reproductive health knowledge, attitudes and practices of Iranian and Afghan men in Tehran province and; Byamugisha et al (2010) in their study; determinants of male involvement in prevention of mother to child transmission program in Mbaye district of Uganda where the qualitative and quantitative data obtained revealed that attitude in both studies was low/negative among the men and a major obstacle to effective utilization of reproductive health.

5.6 Involvement in maternal health

Male involvement in various health practices is recognized as an important factor in improving maternal and child health outcomes. Couple communication and relations, and service utilization are some of the ways in which men could be involved in maternal health. The findings in the study revealed that most men participated and were interested in family planning. The role that they played was seen from the support they gave to their partner's use of family planning. The study revealed that more male than female respondents discussed family planning with their partners. Findings on family planning involvement may be attributed to increase in awareness on family planning services and methods as a way of promoting maternal and child health and the gradual and progressive acceptance of it by men generally.

These results did not relate with most studies which showed that discussions of family planning like other discussions in a home were influenced by the different traditional roles that men and women play which are distinctive and which roles did not overlap. This has continued to place women in subordinate positions when it comes to family planning discussions as the men make
the final decisions in a home even when the decisions may disadvantage the women or may compromise their health. The success associated with such unilateral decision taking has implicitly sustained the subordination of women in most societies and accounts for high fertility (Kritz et al. 2000; Isiugo-Abanihe 1994b). Some studies on family planning suggest that husband’s support or disapproval impacts on the adoption or continued use of contraceptives by women (Tapsoba, 1995).

In addition majority male and female respondents were involved in family planning discussions with a family planning counselor. This gave them a wide range of methods to choose from as they had expertise guidance. These results relate with the in-depth interview results where respondents who were interested in family planning visited the clinic with their spouse for more information. However they were not free because of the environmental setting. Therefore, for respondents to be free to talk to health care providers there was need to initiate good counseling which requires health care providers to respond to the individual needs and concerns of clients. Given gender differences in reproductive health needs, concerns, lifestyle and exposure, men presumably require different communication approaches than women. Health centers need to develop creative initiatives tailored to the unique circumstances of the individual, community and culture (Kim & Kols, 2001).

The study further revealed that most decisions on contraceptive use were made as couples. This is represented by the majority of male and female respondents. Women in the study said that they consulted their husbands on what method to use though they went to the clinics alone and that they received support from their spouses. Most women said that although their husbands supported the use of contraceptives as a way to space the children, most men were not ready to use any form of male contraceptives such as condoms. Accordingly a study on family planning and birth spacing discovered that lack of adequate information on the available male methods and information on family planning, lack of structures to support their participation and cultural factors were identified as hindrances for male active participation in family planning with a health care provider (Kabagenyi et al, 2014).

Regardless of male involvement in method selection the study revealed that most men and women did not seek help as couples from a health provider when family planning effects
occurred. This was because of the distinctive gender roles that men and women play. Men made the final decision on the number of children in a home while birth spacing and decisions on the types of contraceptives to use were preserved for women hence most men did not accompany their partners when effects occurred (Nwokocha, 2008).

The study further revealed that most men were involved more during pregnancy. These results correspond with the results from in-depth interviews which showed that men supported their spouses by attending antenatal clinics with them, undergoing the required tests like HIV with them, and receiving antenatal education with their partners. This helped them have the necessary knowledge required during pregnancy and prepared them for what to expect in case of eventualities.

In addition respondents showed their active involvement by recalling how often they attended antenatal with their partners. Majority of the male and female respondents only attended antenatal clinic together during the 1st visit, the results could be attributed to the current government policies such as the Zambia Reproductive Health Policy (2005), in which male involvement is emphasized. Hence men have no choice than to be present during the 1st visit when all the important tests including HIV are done.

Similar findings have been found by other scholars, a study by Adenike et al, 2013 on perception, attitude and involvement of men in maternal health care in a Nigerian community concluded that men’s presence and their participation at the health facilities during antenatal care visit of their wives will help boost the morale of their wives and also bring about a greater sense of commitment from both parents to having healthy mothers and babies as evident from other studies (Mullick et al., 2005; Cohen et al., 2000; Mullany et al., 2005; Stycos, 1996).

According to responses from both men and women the majority of men gave support to their partners in terms of providing money for antenatal and postnatal care, providing money for skilled birth at a health facility and providing money for logistics and other necessary supplies for delivery. The results tally with the results from the in-depth interviews as respondents agreed having supported their wives by giving them money to buy what they craved for or any other supplies needed for the baby. One respondent said “During pregnancy I give my wife money so
“that she can buy what she wants to eat, sometimes I would buy things for her on my way from work.”

The results are similar to what Muloongo (2015) concluded in his study that men played various roles in antenatal care such as the provision of necessities during pregnancy, acquiring information on pregnancy and the needed care and provision of social and financial support to the wife during pregnancy (Muloongo, 2015).

However, when it came to accompanying the wife to the delivery ward few men were involved the majority did not attempt to go near the labor ward. This was mainly due to the traditional norms and clinical setting and policy of the labor ward which did not allow men to be present. Mullany (2005) in her study found similar findings and suggested that though the introduction of husbands into the delivery room was seen as a somewhat complicated transition, the majority of providers felt that it was an ideal goal to work towards, particularly because husbands could offer vital emotional support, and perhaps logistical support, to the wives throughout the delivery process (Mullany, 2005).

In addition few men were involved in the cleaning and feeding of the baby after delivery. This finding can be attributed to the gender norms which state that immediate care of a new born and mother is the responsibility of the elderly women of the family either mother or mother in-law or aunty. These findings are similar to what Kaye et al (2014) found in their study.

Nonetheless, the study discovered that men were actively involved in discussions with partners about post-partum complications, making sure the children were completely immunized and taking children for under 5 clinic. This level of involvement can be attributed to the respondent’s marital status.

5.7 Perceptions towards male involvement

The study revealed that respondents had a positive perception towards pregnancy being a shared responsibility as majority of the male and female respondents agreed with the statement. This can be attributed to the respondent’s level of knowledge as they were able to understand pregnancy issues and what was encompassed.
In addition almost all the respondents agreed that pregnant women needed care and support during pregnancy and after delivery. This finding agreed with the results from the in-depth interviews as respondents agreed that women needed care and support because of what they went through during pregnancy. One respondent clearly said he would support the wife by cleaning the house, cooking and pacifying the baby so that the wife could rest. Kaye et al (2014) in their study found similar results and concluded that the quality (emotional connection) of the fathers' relationship with the pregnant woman enhances the fathers' expectations, experiences and practices. Childbirth is the time when men are most receptive to getting involved with their families which makes male involvement critical for healthy pregnancy outcomes, infant survival and ideal child development (Kaye et al, 2014).

The study also discovered that majority of male and female respondents were receptive to discussing their wives pregnancy with a health care provider. This showed that men were interested in pregnancy issues but were restrained by culture, work and policies. The roles that men should play during pregnancy were not defined hence some men were reluctant in discussing their wives pregnancy. A study by Ochonga et al, (2016) knowledge, perception and level of male involvement discovered that men were reluctant in accompanying their wives and discussing their wives pregnancy with a health provider because they feared being branded as a jealous husband. Further some men were teased and ridiculed, this discouraged their participation and these results are consistent with the results found in a study in Nepal, (Ochonga et al, 2016).

However majority of male and female respondents had a negative perception towards men's presence in the labor ward. This showed that despite the changing times respondents still believed that the labor ward was exclusively for women. Traditional beliefs, hospital policies and physical setting of the labor ward pose as hindrances to men's presence. These results agree with the findings from the in-depth interviews. Respondents stated that during delivery men were not allowed to be near the ward, they were made to wait in the lobby where they were sometimes chased by the cleaners and nurses. They had no idea about what happened in the labor ward or how far their wives were from delivering, they are only called upon when the baby and mother were safe and back in the admission ward.
Some males perceive child birth as a women’s affair that does not require male partner involvement, this contributes to non-male presence during delivery. These results are similar to other studies, Kaye et al (2014), in their study concluded that some participants felt deep fear about witnessing something going wrong, and were not so eager to be present during delivery. They believed that doctors knew what to do and would do what is best for the patients.

The major sentiment was that while doctors knew what they were doing (had the expertise), they should not make men passive recipients of care. The doctors should at least inform the men about major decisions taken regarding their partners healthcare. The participants further suggested that there should be programs which provide information about this period (childbirth) to men, or provide counseling and support (Kaye et al, 2014). However this was not the case in a study conducted by Mullany (2005) as men were eager to be involved during delivery by being present in the ward so that they could assist in-case of an emergency and support their wives emotionally, though the hospital setting and traditional beliefs of Nepal did not allow for such to happen and this posed as an obstacle to male involvement (Mullany 2015).

5.8 Factors associated with attitudes, involvement and perception towards male involvement in maternal health

The findings in the study indicated that the respondents had a generally positive attitude toward male involvement in maternal health. There was a significant relationship between marital status and knowledge with a p value of 0.03. Respondents who were married were more likely to be knowledgeable as they were most likely to attend antenatal clinic as couples. However there was no relationship between marital status and attitude because attitude was most likely to be dependent on knowledge and exposure to maternal health. This shows that the hypothesis is null as there is no significant relationship between variables. Nevertheless there was a strong relationship between marital status and involvement in family planning. This could be attributed to the many initiated programs on family planning however, there was no relationship between marital status and involvement in attending antenatal as couples. Due to the mandatory tests that were required upon first visitation, both married and unmarried couples attended antenatal with their partners.
In addition there was a statistically significant association between marital status and taking children for immunization. Respondents who were married were more likely to take children for immunization as couples than respondents who were not married. However there was no relationship between marital status and the perception that pregnancy was a shared responsibility. Both unmarried and married male and female respondents were likely to perceive that pregnancy was a shared responsibility because of the knowledge on maternal health. This is in line with a study done by Islam et al (2009) were knowledge determined attitude on health seeking behavior.

There was no relationship between education and level of knowledge. Both educated and not educated male and female respondents were able to recall what they were taught during antenatal clinic and practiced when it came to childbirth and child care. There was also no relationship between education and attitude towards accompanying partner for antenatal, involvement in family planning, involvement in attending antenatal clinic and the perception that pregnancy should be a shared responsibility. This shows that the hypothesis is null as there was no significant relationship between variables.

In this study educational attainment did not necessarily seem to determine attitude as the respondents who had primary education or less were likely to have a positive attitude, get involved in family planning discussions, attend antenatal clinic and a have a positive perception towards pregnancy being a shared responsibility. This was because both educated and less educated respondents attended antenatal care and increased their knowledge on maternal health. This is not in line with a study done by Fetiyestan (2000) where education attainment determined attitude on health care seeking behavior, Dhakal et al (2007) also found similar results.

The study also found that there was no relationship between employment status and level of knowledge, attitude towards accompanying spouse for antenatal clinic, involvement in family planning discussions and attending antenatal clinic with partner. This shows that the hypothesis is null as there is no significant relationship between variables. Respondents who were not employed or did not have an income were likely to be knowledgeable on pregnancy issues. They
were also likely to have a positive attitude and be involved in attending antenatal clinic with partner.

However, the study noted that women who went as far as senior secondary and tertiary education and those who had sources of income either from business or employment had some level of decision making powers when it came to family planning than women with lower levels of education and those without income. Though, the decision making powers they had were jointly owned with their partners. Therefore, in this study, adequate knowledge and positive attitudes and perceptions seems to be major. There was no relationship between employment status and the perception that pregnancy should be a shared responsibility as respondents who were not employed were likely to have a positive perception towards pregnancy being a shared responsibility.

However gender norms still affect perceptions regarding pregnancy, child birth and child care though this is slowly phasing out with the coming of gendered reproductive health programs and gender equality in sexual and reproductive health.

**5.9 Strategies to improve male involvement.**

In order to increase male involvement during pregnancy, delivery and childcare respondents suggested strategies through in-depth interviews. Respondents suggested that hospitals needed to make bigger spaces that would accommodate men attending antenatal care. This would motivate men to attend antenatal clinics as they would have somewhere to sit comfortably while attending the clinic. Additionally respondents suggested that hospitals needed to start making programs that target men because the only role men play when they go for antenatal is get tested for HIV.

This strategy was also suggested in a study by Kaye et al, as respondents felt the hospital environment and services provided, in relation to male involvement, excluded men from what was going on, particularly from the decision-making process regarding the care given to their partners. Further male respondents did not know what roles they had to play as they lacked knowledge on what needed to be done. The hospital environment, the behavior and language of the healthcare providers appeared to increase the participants' feeling of alienation (Kaye, 2014).
Another suggested strategy was that health facilities should extend the service to the weekend so that men who are busy during the week can have time to attend antenatal with their partners during the weekend. This would allow men to attend antenatal care with their wives and get counselled and taught together. Further the service should be extended to the communities. Health workers should go in the communities and sensitize men on the importance of male involvement. Masinga et al, 2004 in their study concluded that Saturday clinics for male partners, VCT education in men’s worksites, market places and provision of printed materials (flyers) increased male involvement, (Masinga et al, 2004)

These findings remain consistent with other studies that suggested community mobilization to enhance male involvement in PMTCT as well as use of community leaders through community outreach, public meetings in places like churches market place as strategies for promoting male involvement, (Burke M.G, 2004).

Lastly respondents suggested that men should be allowed in the delivery room. This was because men do not feel part of the pregnancy because they do not know what women go through. This was also suggested in a study in Nepal by Mullany, 2005.
CHAPTER 6
CONCLUSION AND RECOMMENDATIONS

6.1 Conclusions

Although a high proportion of male respondents in Kafue were aware of antenatal, family planning and postnatal care services, the number of male spouses who actually accompanied their partners for delivery and postnatal care was low as compared to the attendance for antenatal care. Men were willing to be involved in the maternity and postnatal care of their pregnant partners. However there are a number of challenges that must be addressed. These include gender norms, cultural influences, men not being able to take time off work and health provider attitudes. Other noticeable factors highlighted in the study that affect male involvement are; small spaces to accommodate men and their partners, lack of privacy at health centers especially in the delivery room, lack of programs targeting men and men not knowing what roles to play during pregnancy apart from being financial providers.

Involving men will not only improve mother’s and babies’ health but also affect men’s need for reproductive health. The fundamental gender roles/norms remarkably influence male participation in maternal health care. The gender roles and norms are also reflected in maternal health delivery system in Kafue clinics whereby services are female focused. This poses a huge challenge to the health providers as regards to male involvement in antenatal and postnatal care services. However, male involvement in maternal health care is possible if the challenges were quickly conquered. Maternal health care needs to be de-feminized in order to create a foundation for a more equal access to services for both men and women. In addition, pregnancy and child birth education needs to be given to both men and women so that they are equally knowledgeable and fully involved in issues pertaining to maternal health care.

Men who attended maternal health care with their partners did have a significantly higher level of knowledge on maternal health care and held discussions with health providers on issues to do with family planning and pregnancy compared to men who did not attend maternal health care with their partners. Society also frowns upon a man visiting maternal health clinic with his wife saying that he was very controlling this line of thought has extended to health facilities and is reflected in the nurses and midwives attitude and perceptions. Men that actually visit the clinics
find them not so male friendly especially during delivery. Thus they get intimidated. However, establishing the contributing factors to the finding need to be further investigated to establish the messages health workers need to give to the men who attend health services with their spouses in order to encourage consistency and more men to attend.

6.2 Recommendations

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

1. Kafue District Health Office should take steps to raise awareness on the importance and benefits of male involvement in maternal health care through community outreach. This could be achieved through designing messages that specifically target male spouses who accompany their spouses for maternal health care and the involvement of the community health teams and community leaders in reaching out to men and encourage their involvement in maternal health care.

2. Kafue District Health Office should take steps to extend maternal health care services to over the weekend so as to accommodate men who are busy during the week.

3. Develop ways to disseminate information that are acceptable and appropriate for the target group, both men and women.

4. The health centre in-charges together with other staff should train Male Reproductive Health Motivators in order for them to reach out to the men in the community and work places and educate them on the importance of their participation in maternal health care.

5. Antenatal and postnatal care program should be developed for men. This is essential as it would provide information such as adequate nutrition for the expectant mothers, symptoms of certain illnesses and how to look after their partners both physically and psychologically;

6. Kafue District Health Office should improve conditions such as lack of privacy that make it difficult for husbands to participate, and identify other ways health staff could encourage male spouses to be present.
7. Kafue District Health Office should strategically target the most socializing agents such as parents, communities, teachers, churches to reinforce male participation in maternal health and promote gender equality in sexual and reproductive health.

8. There should be a couple level approaches to focus on couples as a unit rather than one at a time. Couple oriented counseling stresses an equal responsibility in maternal health. In relation to the preceding recommendation, it would be imperative for family planning clinics to consider flexible hours for couple counseling taking into account men’s work schedule.

9. Kafue District Health Office should improve interpersonal skills of the health care providers using information about how community (women and men) define care. There may be need for closed sessions among the male leaders and community leaders when discussing cultural or traditional issues that infringe on reproductive health.

10. Existing health services should be made more “male-friendly”, with service providers undergoing symposium training and engaging in effective out-reaches activities.
BIBLIOGRAPHY


Mutemwa, J., (2011). *Community perceptions and attitudes on integrated reproductive health services in Chongwe district Lusaka Zambia*.


Shattuck, D., Kerner, B., Gilles, K., Hartmann, M., Ng’ombe, T., Guest, G., (2011). *Encouraging Contraceptive Uptake by Motivating Men to Communicate About*
**Family Planning:** The Malawi Male Motivator Project. American journal of public health; 101(6): 1089


Thaddeus, S., and Maine, D. (1994). *Too far to walk; maternal mortality in context, social sciences and medicine,* 38:1091-1110


USAID., (2003). Reaching Men to Improve Reproductive Health for All. Interagency Gender


WHO. (2002), Reaching Men to Improve Reproductive Health for All International Conference Dulles, Virginia.


### APPENDICES

**Appendix I**

**QUESTIONNAIRE ABSTRACT**

Questionnaire number………………

<table>
<thead>
<tr>
<th>Question No</th>
<th>Question</th>
<th>Response</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>DEMOGRAPHIC INFORMATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>Sex of the respondent</td>
<td>1. Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. female</td>
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</tr>
<tr>
<td>Q2</td>
<td>How old were you on your last birthday?</td>
<td>é é é é é é é é é é é é é é é .</td>
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</tr>
<tr>
<td>Q3</td>
<td>What is your marital status?</td>
<td>1. Married</td>
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<tr>
<td></td>
<td></td>
<td>2. Cohabiting/dating</td>
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<tr>
<td></td>
<td></td>
<td>3. Separated</td>
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<tr>
<td>Q4</td>
<td>How many children do you have?</td>
<td>é é é é é é é é é é é é é é .</td>
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<tr>
<td>Q5</td>
<td>What is your highest level of education?</td>
<td>1. Never been to school</td>
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<td></td>
<td></td>
<td>2. Primary school</td>
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<td></td>
<td></td>
<td>3. Secondary school</td>
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<td></td>
<td></td>
<td>4. Tertiary school</td>
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</tr>
<tr>
<td>Q6</td>
<td>What is your occupation?</td>
<td>1. Formal employment</td>
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<tr>
<td></td>
<td></td>
<td>2. Informal employment</td>
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<td></td>
<td></td>
<td>3. Business</td>
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<td></td>
<td></td>
<td>4. Other specifyé é é é .</td>
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<tr>
<td></td>
<td><strong>KNOWLEDGE ON MATERNAL HEALTH</strong></td>
<td></td>
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<tr>
<td>Q7</td>
<td>Do you know about antenatal care?</td>
<td>1. Yes</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>2. No</td>
<td></td>
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<tr>
<td>Q8</td>
<td>What are the advantages of antenatal care?</td>
<td>Monitoring the growth of the child.</td>
<td>1 0</td>
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<tr>
<td></td>
<td></td>
<td>To know the health of the mother</td>
<td>1 0</td>
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<tr>
<td></td>
<td></td>
<td>To detect and prevent complications</td>
<td>1 0</td>
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<tr>
<td></td>
<td></td>
<td>Helps to understand pregnancy, birth</td>
<td>1 0</td>
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<td></td>
<td></td>
<td>Helps to plan for and have safe delivery.</td>
<td>1 0</td>
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<tr>
<td></td>
<td></td>
<td>Promotes healthy lifestyle for mother and child</td>
<td>1 0</td>
</tr>
<tr>
<td>Q9</td>
<td>What are the advantages of post-natal care?</td>
<td>Self-confidence</td>
<td>1 0</td>
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<tr>
<td></td>
<td></td>
<td>Less postpartum depression</td>
<td>1 0</td>
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<tr>
<td></td>
<td></td>
<td>Feelings of support and love from partner</td>
<td>1 0</td>
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<tr>
<td></td>
<td></td>
<td>Increased baby soothing skills</td>
<td>1 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better prepared for what to expect from new born</td>
<td>1 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater sense of communication with infant</td>
<td>1 0</td>
</tr>
<tr>
<td>Q 10</td>
<td>What tests does a pregnant woman need to undergo during antenatal check-up?</td>
<td>Blood screening for HIV infection</td>
<td>1</td>
</tr>
<tr>
<td>Q 11</td>
<td>What does a pregnant woman need in order to stay healthy?</td>
<td>Calcium supply</td>
<td>1</td>
</tr>
<tr>
<td>Q 12</td>
<td>Do you know about mother to child transmission?</td>
<td>1. Yes</td>
<td>2. No</td>
</tr>
<tr>
<td>Q 13</td>
<td>When is a pregnant woman tested for HIV in antenatal care?</td>
<td>1. During the first visit</td>
<td>2. During the second trimester</td>
</tr>
<tr>
<td>Q 14</td>
<td>What are the ways of preventing mother</td>
<td>Provision of ARV prophylaxis</td>
<td>Tick all</td>
</tr>
<tr>
<td>Q 15</td>
<td>At what stage of pregnancy is newborn deformity most likely happen?</td>
<td>1. 12 weeks</td>
<td>2. 12-28 weeks</td>
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<tr>
<td>Q 16</td>
<td>What are the signs and symptoms of high risk pregnancies?</td>
<td>Excessive vomiting 1 0</td>
<td>Vaginal bleeding 1 0</td>
</tr>
<tr>
<td>Q 17</td>
<td>What should be done when a pregnant woman shows signs and symptoms of high risk pregnancy?</td>
<td>1. Report to health center</td>
<td>2. Home remedies/self-medication</td>
</tr>
<tr>
<td>Q 18</td>
<td>What are the causes of maternal mortality?</td>
<td>Age 1 0</td>
<td>Excessive bleeding after delivery 1 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>to child transmission of HIV?</th>
<th>to the mother or child</th>
<th>1</th>
<th>0</th>
</tr>
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<tbody>
<tr>
<td>By taking herbal medicine</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>By taking antiretroviral drugs</td>
<td>1</td>
<td>0</td>
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<tr>
<td>By taking pre exposure prophylaxis</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Question</td>
<td>Choice</td>
<td>Description</td>
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<tr>
<td>Q 19</td>
<td>1. Yes</td>
<td>Do you think that any infection during pregnancy can cause harm to the baby?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. No</td>
<td></td>
<td></td>
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<tr>
<td>Q 20</td>
<td>1. Yes</td>
<td>Do you think that Proper nutrition for a pregnant woman prevents fetal abnormalities?</td>
<td></td>
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<td></td>
<td>2. No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q 21</td>
<td>1. Yes</td>
<td>Are you aware that any medicines other than those prescribed by doctor can cause harm to your baby?</td>
<td></td>
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<tr>
<td></td>
<td>2. No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q 22</td>
<td>1. Yes</td>
<td>Are you aware that a sterilized thread is used to cut and tie the cord?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q 23</td>
<td>1. Yes</td>
<td>Should a child be taken for vaccination?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q 24</td>
<td>1. After 6 months</td>
<td>When should a child be weaned?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. After 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. After 18 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Other specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q 25</td>
<td>1. Yes</td>
<td>Do you use oral rehydration therapy when your child has diarrhea?</td>
<td></td>
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<tr>
<td></td>
<td>2. No</td>
<td></td>
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</tr>
</tbody>
</table>

**GENDER NORMS TOWARDS MALE INVOLVEMENT MATERNAL HEALTH**

**Instruction:** For the following questions kindly tick on agree or disagree for each statement.
| Q 26 | Attending antenatal clinics is exclusively for women. | 1. Agree  
2. Disagree |
| Q 27 | A man should accompany his wife/partner to the labor ward/Delivery room. | 1. Agree  
2. Disagree |
| Q 28 | A man should help with household chores when a woman is pregnant or busy with the baby. | 1. Agree  
2. Disagree |
| Q 29 | Men should help with sterilizing the cord and cleaning the baby after delivery. | 1. Agree  
2. Disagree |
| Q 30 | Men as financial providers affect the level of male involvement in family planning/antenatal care and postnatal care. | 1. Agree  
2. Disagree |
| Q 31 | The role of women as mothers and caregivers affects male involvement in postnatal care. | 1. Agree  
2. Disagree |
| Q 32 | A man should take his child/children for immunization. | 1. Agree  
2. Disagree |

**ATTITUDES TOWARDS MALE INVOLVEMENT IN MATERNAL HEALTH**

| Q 33 | Men should accompany their spouse/partner for antenatal clinic. | 1. Agree  
2. Disagree |
| Q 34 | Men should encourage family planning. | 1. Agree  
2. Disagree |
| Q 35 | Family planning encourages promiscuity. | 1. Agree  
2. Disagree |
| Q 36 | Husbands should attend antenatal and postnatal care with spouse. | 1. Agree  
2. Disagree |
| Q 37 | Men should provide finances for antenatal care. | 1. Agree  
2. Disagree |
| Q 38 | Men should provide finances for transport to the health facility during delivery. | 1. Agree  
2. Disagree |
| Q 39 | Husbands should offer assistance during pregnancy and childcare. | 1. Agree  
2. Disagree |
| Q 40 | Pregnant women should change dietary habits as advised by doctor. | 1. Agree  
2. Disagree |

**IN VOCALMENT IN MATERNAL HEALTH**

*Instruction: For the following questions kindly tick on either yes / no for each question.*

| Q 41 | Do you discuss family planning with your wife/ partner? | 1. Yes  
2. No |
| Q 42 | Do and your spouse participate in family planning discussions with a family planning counselor? | 1. Yes  
2. No |
| Q 43 | Do you and your wife talk about what family method to use? | 1. Yes  
2. No |
| Q 44 | Do you as a couple seek help from a health provider when family planning effects occur? | 1. Yes  
2. No |
| Q 45 | Do you and your wife/ partner attend antenatal clinics together? | 1. Yes  
2. No |
| Q 46 | How often do you attend antenatal and postnatal clinic with your spouse/ partner? | 1. Every week  
2. Every month  
3. Every three month  
4. Others specifyé |
| Q 47 | Do you both provide money for antenatal and postnatal care? | 1. Yes  
2. No |
| Q 48 | Do you both provide money for skilled birth at a health facility to ensure safe delivery? | 1. Yes  
2. No |
| Q 49 | Do you pay for transport ahead of time and buy the necessary supplies for delivery? | 1. Yes  
2. No |
| Q 50 | Do you both support your wife/partner during delivery by being present in the ward? | 1. Yes  
2. No |
| Q 51 | Do you help out with the cleaning and feeding of the baby? | 1. Yes  
2. No |
| Q 52 | Do you discuss with your wife/partner about post-partum complications? | 1. Yes  
2. No |
| Q 53 | Do you both make sure the children are completely immunized? | 1. Yes  
2. No |
| Q 54 | Do you both take your children for under 5 clinics? | 1. Yes  
2. No |

**PERCEPTIONS TOWARDS MALE INVOLVEMENT IN MATERNAL HEALTH**

**Instruction:** For the following questions kindly tick on agree or disagree for each statement.

| Q 55 | Pregnancy should be a shared responsibility between couples | 1. Agree  
2. Disagree |
| Q 56 | A pregnant woman needs care and support during pregnancy and after delivery? | 1. Agree  
2. Disagree |
| Q 57 | Discuss your wife's pregnancy with a | 1. Agree  
2. Disagree |
<table>
<thead>
<tr>
<th>Q 58</th>
<th>Men should be present in the delivery room?</th>
<th>1. Agree</th>
<th>2. Disagree</th>
</tr>
</thead>
</table>

**END OF QUESTIONNAIRE THANK YOU**
### Appendix II

**INTERVIEW GUIDE FOR MEN**

<table>
<thead>
<tr>
<th>Question no</th>
<th>question</th>
<th>probe</th>
</tr>
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<tbody>
<tr>
<td><strong>Objective: to assess the level of knowledge among men</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Gender norms</td>
<td>Describe what happened during your visit to the antenatal clinic?</td>
<td></td>
</tr>
<tr>
<td>2. Attitudes</td>
<td>Describe the type of support you give to your wife during pregnancy, delivery and after?</td>
<td>How do you help your partner stay healthy during pregnancy?</td>
</tr>
<tr>
<td>3. Perception</td>
<td>In what areas of reproductive health matters do men generally participate in?</td>
<td>Explain how you participate?</td>
</tr>
<tr>
<td><strong>Objective: to examine gender norms, attitudes and perception of men in maternal health care.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Gender norms</td>
<td>What is your view on men attending to women during pregnancy and after delivery?</td>
<td>Explain how you help out with house chore and taking care of the baby.</td>
</tr>
<tr>
<td>2. Attitudes</td>
<td>What are your experiences with health facilities in relation to male involvement?</td>
<td>During antenatal, delivery and postnatal care.</td>
</tr>
<tr>
<td>3. Attitudes</td>
<td>What should be done to encourage men to participate in antenatal and postnatal health?</td>
<td></td>
</tr>
<tr>
<td>4. Perception</td>
<td>Describe other issues that are overlooked by men but affect male involvement in antenatal, child birth and postnatal care?</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix III

**INTERVIEW GUIDE FOR WOMEN**

<table>
<thead>
<tr>
<th>Question no</th>
<th>Question</th>
<th>Probe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Gender norms</strong></td>
<td>What are some of the cultural beliefs relating to male involvement during pregnancy and delivery?</td>
<td>How have these beliefs affected your partner’s involvement during pregnancy, childbirth and delivery?</td>
</tr>
<tr>
<td>2. <strong>Attitude</strong></td>
<td>Describe the type of care and support you received from your partner after delivery?</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Attitude</strong></td>
<td>Describe how your partner gets involved in postnatal care?</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Attitude</strong></td>
<td>Describe (if any) the kind of abuse you are subjected to as a result of pregnancy from your partner?</td>
<td>Mental or physical</td>
</tr>
<tr>
<td>5. <strong>Perception</strong></td>
<td>What are some of the reasons why men do not participate before and during delivery?</td>
<td></td>
</tr>
</tbody>
</table>

END OF INTERVIEW. THANK YOU.