

INTRODUCTION

The World Health Organisation (WHO) defines ante natal care also known as pre-natal care, as the complex interventions that a pregnant woman receives from organized health care services. It also refers to the care that is provided to pregnant women from conception to onset of labour, (WHO report, 2001, p.27). These interventions may be provided in approximately 4 focused antenatal care visits during a pregnancy. WHO recommends that in these visits interventions such as tetanus toxoid vaccination, screening and treatment of infections and identification of warning signs during pregnancy are carried out. The purpose of antenatal care is to prevent or identify and treat conditions that may threaten the health of the fetus/newborn and/or the mother, and to help a woman approach pregnancy and birth as positive experiences, (<http://www.unicef.org/Zambia/51098457.html>, accessed on 1st December, 2012).

According to the Global Health Observatory (2012, p. 2) globally, during the period 2005-2012, about 55% of pregnant women attended the recommended minimum four times ante natal care. The report also revealed that the proportion of pregnant women in developing countries who attended at least four ante natal care visit has increased from approximately 37% in 1990 to about 50% in 2011. The need for men to be involved in ante natal care cannot be overemphasized. Male involvement is cardinal for increased ante natal coverage and the reduction of maternal mortality. According to Lee (1999, p.111) male involvement includes the following as part of the men's participation: attending women's health education sessions, attending counseling sessions and acting as community based volunteers. For Rutenburg and others, (2002,p.29-30), men's involvement may mean that men choose to come to the clinic with their partners, be counseled and get tested for HIV, support their partners in coping with HIV infection and support them financially or with transport to the clinic.

This research was carried out to evaluate communication strategies employed by the Mkushi district community medical office under the Ministry of Community Development, Mother and Child Health in promoting male involvement in ante natal care among health care providers, men

and women. It looked at the channels, messages, sources of information on male involvement and the perceived barriers to male involvement in ante natal care.

The first chapter of this report gives an overview of male involvement in ante natal care world over and in Zambia this will be preceded by the general background of ante natal care in Zambia and then the problem statement. It also shows the rationale and the objectives outlined. Furthermore, this report reviewed the available literature on the topic in chapter two. In chapter three the report elaborates how the research was conducted in terms of methodology. The conceptual and theoretical frame work is dealt with in chapter four. The data collected during the research is analyzed in chapter five and discussed in chapter six. The discussion in chapter six was done in line with the objectives. Finally, the report will conclude and give recommendations in chapter seven.

CHAPTER ONE

1. BACKGROUND INFORMATION

Ante natal services were first made available and provided to expectant mothers in Britain in the early 1900s. These services were a division of therapeutic and preventive medicine (Browne and Dixon, 1970, p.12). The services were intended not only to take care of medical issues but also to demonstrate to expectant mothers in order for them understand its potential advantage and also for the importance of nutritional and social conditions conducive to good quality healthy lives. According to Suya (2000, p.7) ante natal services were introduced to Zambia, the then Northern Rhodesia, in the 1930s. The services were largely delivered to the British community. In the early 1960s, there was an enormous campaign through the department of Health and Social Services encouraging expectant mothers to register at the nearest health centre for ante natal sessions. Over the years ante natal services have evolved with an increased emphasis on male involvement.

During the mid-1960s the country had excellent health services though widely spaced. These services were provided by the government and the mines. By 1975, with the dwindling copper prices and the increase in the cost of fuel, Zambia's economy fell and this had a negative impact on the health delivery system (Ministry of Health, 1996, p.1). By 1985, the health sector was barely able to provide basic health care to the people. Though these services were accessed at no cost in a centrally controlled system, the services were inefficient and costly to the government (Ministry of Health, 1996, p.2). With the coming of the 1990s, it was realized that the health of the people could only be improved if the system underwent major reforms.

The year 1995 saw the provision of health services in Zambia go through massive changes through policy reforms (Ministry of Health report, 1996, p.2). Through the health reforms, there was a decentralization of health services, thereby giving autonomy to the newly established District Health Management Boards (Ministry of Health report, 1996, p.2). These boards were given authority to plan, allocate and manage funds in the implementation of different district

health activities. The boards have since been dissolved and the Ministry of Health has since been restructured.

However, the provision of health services continues to face different challenges to date. These challenges include inadequate maintenance of health facilities, shortage of drugs and medical supplies, inadequate professional personnel and inadequate funding in the operation of the existing facilities. The government continues to put emphasis on the improvement in the provision of primary health care to the communities especially in the rural areas. This is being done through different programs with safe motherhood through male partner involvement in ante natal care as one of the priority areas that is seen to be receiving attention in a bid to reduce maternal mortality. This campaign continues today as there has been a new recognized emphasis on the need to involve men in activities pertaining to ante natal care as a way of reducing maternal mortality.

1.1. An Overview of Global Maternal Issues

Today with high levels of maternal mortality persisting in developing countries, especially in Africa, there is increasing interest in identifying ways through which women can access appropriate care to prevent deaths during pregnancy. Although the number of maternal deaths has been declining, they are still far from the targets set by the Millennium Development Goals (MDGs) in most developing countries. According to the Millennium Development Goal number five (5) which is to improve maternal health, the target set for this goal is still yet to be met with only a year remaining to the set target date. According to the WHO report on Gender and Women's Health (2003, p.4) the target under this goal is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. Although this goal directly targets women the conditions that heighten or diminish the problem have a gender dimension as men also have a critical role to play. For instance, societal norms that sometimes require women to obtain the consent of the husband and a male family member before seeking health care can dangerously delay or prevent women from accessing lifesaving care in case of an emergence especially a maternal one. It is also believed that a woman's education is strongly related with positive maternal outcomes as high illiteracy levels are likely to contribute to maternal mortality.

Globally, it is estimated that 500,000 women die every year due to pregnancy and childbearing related causes and 99% of these deaths are in developing countries and Zambia contributes to this figure. The main reason for the high number of deaths is attributed to insufficient and poor-quality maternal health care during pregnancy, WHO report (1999, p.24). Zambia today has one of the highest maternal mortality rates in Africa. In 2007, the maternal mortality rate and the new born mortality rate stood at 591 per 100,000 and 34 per 1000 respectively, (<http://www.unicef.org/Zambia/51098457.html> accessed on 7th December, 2012). The maternal mortality rate MDG target for Zambia is 162 per 100,000 by 2015.

Pregnancy and childbearing is an important function that is necessary for the preservation of the human species but often comes with possible risks and this calls for the support of family particularly the husband, community and country as a whole. According to Professor Mahmoud Fathalla an obstetrics and gynaecology professor at the university of Assult in Egypt, in his speech at the National Reproductive Health Summit in Abuja Nigeria in 2008 “women are dying during pregnancy and child birth not only because of conditions that are difficult to manage, but women are dying because the society in which they live did not see it fit to invest in what is needed to save their lives”. Pregnancy and childbirth should ideally be a time of joy for the family and society, however in most cases the reality of motherhood is often accompanied by life threatening experiences. Therefore, it is important that their male partners should support them fully to abate the situation and ensure safer pregnancies.

1.2. Male Involvement in Ante natal Care in Zambia

Male involvement in maternal health care in terms of male partners accompanying their partners for ante natal care sessions is a relatively new approach in Zambia. The Ministry of Community Development, Mother and Child (MCDMCH) in the recent past has embarked on programs that are emphasizing men’s key role in reducing maternal deaths and promoting their involvement in ante natal care. This was following the recommendations of the International Conference on Population and Development (ICPD) in 1994 and the fourth conference of women in Beijing in 1995 that stressed the need for male involvement in reproductive health and their shared responsibility and active involvement in responsible parenthood in order to improve the health of

women and children. These programs aim to reduce maternal deaths while encouraging men to take an active role in their partners' pregnancies (WHO report, 2001, p.27).

Traditionally, maternal health care services have focused on women, with very little male involvement. Male involvement in ante natal care has not been accorded the attention it deserves. However, evidence show that men who are well informed about their sexual and reproductive health are more likely to make better health choices for themselves, their partners, and their families than men who lack this knowledge, (http://www.guttmacher.org/pubs/itor_intl.pdf accessed on 16th February, 2014). Given that male involvement in maternal health care is a relatively new phenomenon, and it touches on the sensitive nature of gender roles related to culture, social norms, values and beliefs; understanding how the program is being communicated to people and knowing people's perceptions about the program is critical for its success. In addition, introduction of a new health or social and behavioral change activity, as is the case with male involvement in Zambia, is a fundamental step in designing appropriate interventions for quality maternal health services. There seems to be a growing belief that the role of men in women's access of health care is very relevant given their large role in family decision making.

The concept of male involvement in ante natal care is now being advocated as an essential element of the World Health Organization (WHO) initiative for making pregnancy safer. Men's knowledge about danger signs of pregnancy and what to do about them is very relevant to their life-saving role during pregnancy and childbirth. The important role that male partners play in women's reproductive health is becoming increasingly recognized especially with the high rate of maternal deaths, more attention is being focused on how to incorporate men into reproductive health education interventions. Communication and education interventions for pregnancy health have traditionally been inadequate in addressing a woman's degree of influence within the household on health-related decisions, particularly as compared with her husband.

Understanding the Communication strategies of male involvement to men, women and health care providers may lead to better understanding of the existing barriers to male involvement in ante natal care. Overall, there seems to be a general agreement that those men who have knowledge of maternal healthcare services encourage their wives to receive such care with

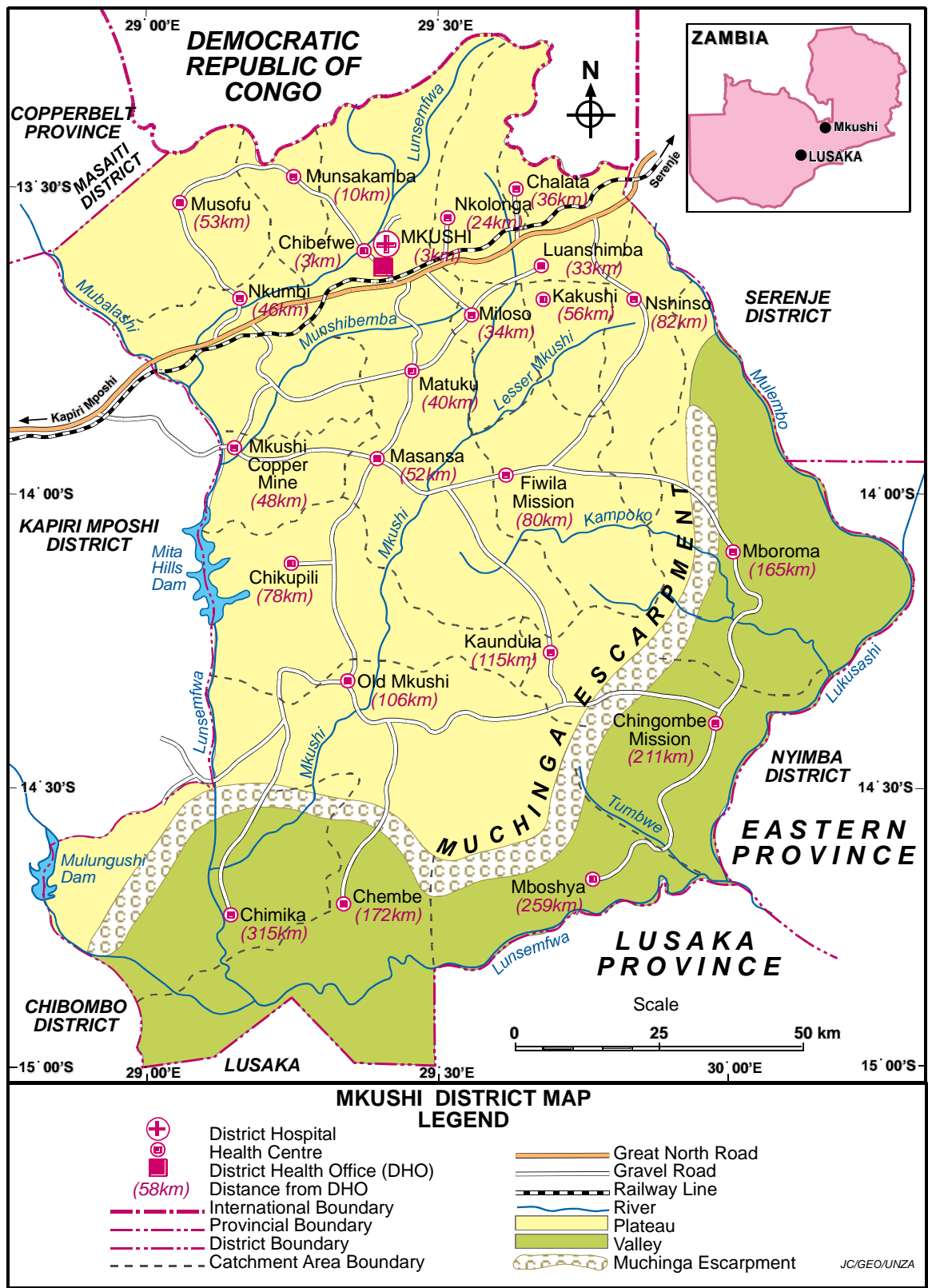
beneficial outcomes. Such women have greater ability to access and use a health facility for skilled delivery or postnatal care. With household decision making often in the hands of men or other household members, women are often constrained in the utilization of maternal health services and also their ability to use a health facility for delivery. Greater male involvement gives them an opportunity to benefit from such care.

1.3. Mkushi District Profile

1.3.1. Geography

Mkushi District is situated in Central Province of Zambia and covers a surface area of 9,495 square kilometers. It shares boundaries with the Democratic Republic of Congo in the North, Masaiti District to the North West, Kapiri Mposhi to the west, Chibombo to the South West, and Serenje District to the North East.

Below is the map of the district:



Extracted from Mkushi District Health Action Plan 2014-2016

1.3.2. Community Health Services in the District

Mkushi District Medical Office oversees health services in the district. The district has one first level referral hospital called Mkushi District Hospital. There are a total of 10 health centres and 12 health posts directly managed by the District Medical Office offering primary health care services in the district. The hospital and the health centres provide curative, rehabilitative, promotional and preventive health services on a daily basis. In addition to attending to the population within the district, some patients also seek health services in the district from other neighbouring districts including patients from the Democratic Republic of Congo (Mkushi District Health Action Plan 2014-2016 p.11).

1.3.3. Road Network

The Great North Road is the main road which services Mkushi District in the transportation of logistics and supplies from Lusaka and links the district to other parts of the country. Within the district are many feeder roads which are key in the transportation of rural produce and inputs. However, due to the bad terrain and geographical features, most of these roads become impassable during the rainy season. Furthermore, the district is serviced by the Zambia-Tanzania rail-line. This rail-line links the district to Kapiri Mposhi and Serenje but is also a reliable route to East African countries (Mkushi District Health Action Plan 2014-2016 p.11).

1.3.4. Socio-economic Status

Mkushi District, being centrally located is among the five (5) remote districts in Zambia earmarked for major economic boom as a result of the opening of a Copper mine by 1st Quantum minerals and other many minor mining companies. Farming is the major economic activity and source of livelihood for the people. It is mainly done by the emigrants from both within and outside the country and comprise of commercial and small scale farmers.

Most indigenous (local) people who are not in formal employment are involved in labour force participation as farm laborers, piece workers in the township and the small mining firms. However a good number of people in the central business district are involved in small scale

enterprises in form of grocery stalls, barber shops, taverns, just to mention a few. Most people both in urban and rural areas of the district are poor and cannot meet the cost of items in the minimum food basket. Households survive by reducing the number of meals in a day to less than three as well as forfeiting basic requirements such as soap, sugar, cooking oil and other essentials. The majority of the people live in substandard houses both in Urban and Rural areas. Houses are usually made of pole and dagger with thatched roofs and have no proper water supply and sanitary facilities, a factor that greatly contributes to the incidence of water borne diseases.

The district central business area houses big, medium and small business structures which include shops, services stations, banks and other service providers (Mkushi District Health Action Plan 2014-2016 p.12).

1.3.5. Education Status

The District has over 95 basic schools and four high schools, one college and two farmers training centres. Further, there are many private schools of which Chengelo International School is the most prominent (Mkushi District Health Action Plan 2014-2016 p.12).

1.3.6. Ethnicity

The traditional ceremony for the Bisa, Lala and Swaka tribes known as Chibwelamushi takes place annually in Chalata area of the district (Mkushi District Health Action Plan 2014-2016 p.12).

1.4. Statement of the Problem

Male involvement in ante natal care is a relatively new approach in Zambia and the Ministry of Community Development Mother and Child Health has embarked on the implementation of programs that are emphasising men's key role in reducing maternal mortality through promoting their involvement in ante natal care. Though the Ministry of Community Development, Mother and Child Health and its partners have embarked on the male involvement in ante natal care program, the number of women attending ante natal care visits with their spouses appears to be very low. According to the Health Information Management Systems report (HMIS) 2012 for

Mkushi District, out of 5,911 women who attended ante natal in the district only 3,160 were accompanied by their partners. The picture is almost the same in 2013 where out of 5,542 women who attended ante natal only 2,815 were accompanied by their partners.

It appears that may be communication strategies that promote male involvement in ante natal care in Mkushi District seem to be insufficient and have so far not yielded the expected positive results of having an increased turn out of men accompanying their partners for ante natal. Communication strategies for ante natal care appear to be inadequate in highlighting the critical life-saving role men can play during pregnancy and subsequently childbirth. The majority of men still seem to be lacking knowledge about the danger signs of pregnancy and what to do about them. This knowledge is important to the life-saving role they can play during pregnancy and childbirth.

1.5. Justification of the study

This study evaluated the communication strategies which were being used by the Ministry of Community development, Mother and Child Health in promoting male involvement in ante natal care; this was done by looking at whether key steps involved in communication for behavioural and social change had been incorporated. This study may help the Ministry of Community Development, Mother and Child Health to come up with improved and effective messages on male involvement that may help increase the number of men participating in ante natal care.

The results of this study would also contribute both to the understanding of the challenges faced by the community in respect of male involvement in ante natal care and lead to the improvement of the maternal health services in this regard. The study further highlighted the necessity for further research on this subject as not much research has been done in Zambia on this subject. The research may also lead to health policies that may bring about ante natal activities that are more male friendly and incorporate participatory communication in all ante natal interventions.

1.6. Objectives

1.6.1. General Objective

To evaluate the communication strategies being used by the Mkushi District Medical Office to promote male involvement in ante natal care.

1.6.2. Specific Objectives

1. To establish the types of communication networks existing within the community medical office as an organisation concerning male involvement in ante natal care
2. To determine what messages the District Community Medical Office communicates to the community.
3. To examine the communication strategies used by the district medical office in promoting male involvement in ante natal care
4. To find out the perceived barriers faced by men in trying to get involved in ante natal care.
5. To ascertain the types of communication which exist between couples and health providers concerning male involvement in ante natal care.

1.7. Research Questions

1.7.1. General Question

What is the impact of the communication strategies being used by Mkushi Community Medical Office to promote male involvement in ante natal care?

1.7.2. Specific Questions

2. What types of communication networks exist within the District Community Medical Office concerning male involvement in ante natal care?
3. What messages does the District Community Medical Office communicate to the community on male involvement in ante natal care?

4. What communication strategies does the district medical office use in promoting male involvement in ante natal care?
5. What are the perceived barriers faced by men in trying to get involved in ante natal care?
6. Which media does the community has access to for information on male involvement in ante natal care?

CHAPTER TWO

2. LITERATURE REVIEW

2.1. Introduction

The Ministry of Community development, Mother and Child health through its organs coordinates a number of behavioral and social change programs. One such program is the male involvement in ante natal care. This program is being intensified with the view of reducing the number of maternal deaths and assures children of a healthy childhood with both parents involved unlike the case in the past whereby it was mostly the responsibility of women.

A number of studies have been conducted around the world on the importance of male involvement and some of the barriers to the success of this program. This chapter now looks at some of the studies conducted around the world on the subject to learn from the findings. There is however limited literature on the communication strategies used to sensitize the communities around the world on male involvement in ante natal care. Most available literature looks at the subject generally not specifically in the communication perspective.

2.2. Promoting male involvement in ante natal care in Papua New Guinea – Knowledge, Attitudes and Practices Study

According to key findings in a study conducted in Papua New Guinea in 2011, investigating a community knowledge, attitudes and practices (KAP) relating to male involvement in ante natal care, most fathers do not attend clinics with their pregnant partners and men's use of Sexual Reproductive Health (SRH) services is quite low. This study which was carried out by the Department of Health with support from UNICEF, brings out evidence that while men agree, it is important for women to attend ante natal care, many factors contribute to preventing men from being involved while women participants in the study highlighted that having a supporting husband promotes ante natal attendance and freedom to access services. This KAP study brings out three important issues:

- Expecting women are highly likely to come for ante natal if they have a supportive husband or if it is the first pregnancy.
- Many men have genuine concerns for the health of their wives and unborn baby but need information to engage in seeking care for their pregnant spouse and partners.
- Many men identify several barriers to their participation in ante natal care which include shame and embarrassment due to traditional beliefs and norms that ante natal attendance is a women's responsibility, male unfriendliness of health facilities, attitudes of health workers and varied ideas on appropriate timing of ante natal care consultations, (www.unicef.org/png/media_2011, accessed on 23/01/2014).

2.3. Qualitative Study on Barriers to Male Involvement in Maternal Health Care in Malawi

A qualitative study was carried out in Mwanza District of Malawi on the barriers to male involvement in maternal health care by Kululanga et al., in March 2012. According to Kululanga and others (2012, p.46) from the focus group discussions that were conducted during the study the following were the findings: it was revealed that some wives were unwilling to have their husbands participate in ante natal care. The women participants explained that despite the health care providers asking women to come with their husbands during the subsequent ante natal visit, some choose not to invite their husbands. One of the reasons given was that some women were not comfortable discussing ante natal issues in their husband's presence.

Another hurdle the research revealed was the infrastructure at the health facility; this factor was consistently identified by the focus groups, key informant and health care providers. Maternal Health Care (MCH) clinics and services were gendered such that men felt unease to be seen in such feminine places. It was observed by the researcher that ante natal care services were offered in an open space that denied both men and women the physical and verbal privacy they deserved. Due to this lack of privacy most men opted not to participate in ante natal care at the health facilities. Some men explained that they opted not to participate as a sign of respect to the women.

The study also found out that most men lacked knowledge about male involvement in ante natal care. This entails lack of knowledge as in the actual activities that the men would participate in at the ante natal care clinics. Men's knowledge about male involvement in maternal health care is a starting point for participation. However, some men expressed ignorance and others did not understand why they had to be involved. Similar findings have been documented by Aarnio and others, 2009. He found similar results in a study conducted in Malawi that focus on male involvement in antenatal HIV counseling and testing (Aarnio et al 2009 p 67) It was revealed that there were no clearly planned out activities for the men especially after the first ante natal visit. The men that missed the sensitization campaigns and whose wives did not communicate to them about the importance of husband involvement expressed ignorance about husband participation in maternal health care.

The findings of the study do not, however, indicate how the sensitization campaign was carried out and what could have led to some men missing out on the messages from the campaign. The study does not also reveal the exact messages that were being spread in the sensitization campaigns done in this area. Knowing the exact messages in the sensitization campaigns was critical to this study as it could have helped the study to find out whether the messages talked about the actual activities that men could participate in and also exactly how these messages were being communicated to the community. Perhaps if the messages and channels were not done properly this could pose a barrier to male involvement in ante natal care. The study would have found out whether the messages in the sensitization campaign could have influenced the expectations of men as they go to the ante natal.

The information, education and communication messages (IEC), which are part of the services in this setting, target women maternal health care need to be de-feminized in order to create the foundation for a more equal access to services for both men and women. The health care sector needs to consider seriously the privacy issue in the delivery of maternal health care for male involvement as well as for the dignity of the women (Aarnio et al 2009 p 67).

2.4. The Involvement of Men in Ante natal in KwaZulu-Natal Province in South Africa

In South Africa, a study was carried out by the Reproductive Health Research Unit (RHRU) at the University of Witwatersrand aimed at involving men in maternity care in 2001. The study was conducted in Kwazulu- natal Province. The province has a population of 9.1 million people, with over half (57%) living in rural areas. The literacy rate for the province was reported as 89 percent which is above the national rate of 85 percent. Eighty-one percent of the population is African, mainly Zulu, with strong cultural beliefs about the role of men in antenatal and postnatal care. Men are not expected to be involved in maternity related issues with some believing that a man will become weak if he is present at the birth of his baby. The HIV prevalence among antenatal clients in Kwazulu-natal was 33.5 percent in 2002 and the maternal mortality rate increased from 188 per100 000 in 1998 to 243 per100 000 in 2001, with 23 percent of these deaths being HIV related (RURH 2004, p24)

Male involvement and communication reflected positive responses to men becoming involved in almost all aspects of the ante natal care process with some hesitation around labour and delivery. In part this may reflect concerns about waiting facilities and privacy in labour and delivery wards (RURH, 2004, p.24). The study also found that both men and women are interested in men's involvement during maternity care. However, the study found that knowledge needs improvement and men's and couples' involvement during maternity services as well as appropriate Information Education and Communication (IEC) materials could be a means to achieve this. And also that it is feasible and potentially effective to have couplecounselling in public sector clinics, even if only a proportion of men will be able to participate (RURH 2004, p.24).

However, there are a number of health delivery challenges that need to be addressed within the South African health context before maternity services become either friendly or acceptable to men (Mullick, Kunene &Wanjiru, 2005, p.32). The challenges that were identified that prevent

male partners from becoming involved in reproductive health services as indicated above include the following:

- Reproductive health services such as family planning, pregnancy and childbirth are regarded as exclusively the domain of women and, generally, men do not accompany their partners to facilities offering such services.
- Men feel that they derive no benefit from the information furnished by health providers.
- Men are rarely exposed to clinical reproductive health services as they tend to seek care for Sexually Transmitted Infections (STIs) in the private sector. It is not possible to obtain condoms without some form of contact with health care providers.
- Logistical (resources) and cultural problems render male partners inaccessible to Reproductive Health services.
- The exclusive use of such services by women has to a great extent made these Reproductive Health services unfriendly for men.

According to Mullick, Kunene and Wanjiru (2005, p.33) in order for male involvement in the maternity care of their partners to be a success, the study came up with the following recommendations:

- Undertake wider community outreach so that more men can be persuaded to participate in their partners' maternity care.
- Develop ways to disseminate information that are acceptable and appropriate for the target group, both men and women.
- Reorganize public services to be friendly and flexible to both men and women who are working during the day.
- Strengthen monitoring and supportive supervision for all health services.
- Train more health providers to serve couples and to conduct couple counselling.
- Integrate other reproductive health services such as Sexually Transmitted Infections (S.T.I), family planning, voluntary counselling and testing, and prevention of mother to child transmission with antenatal and postnatal care.

- Involve hospital staff to support men who may want to be with their partners during delivery.

2.5. Male Involvement in Reproductive Health in Namibia

In Namibia, a study was conducted in Oshikoto region by H.J Amukungo in August, 2009 on developing a model for male involvement in Reproductive Health. The aim of this study was to analyse the concept of male partner involvement in the Reproductive Health by exploring and describing the perceptions of male partners, female partners and nurses on this issue.

From the findings of this study, it became evident that the main reason why male partners are not involved in Reproductive Health is poor interaction (partnerships) among male partners, female partners and nurses as well as other significant stakeholders in the community and health facilities environments. In short, one may conclude that there is poor interaction (partnerships) between male partners and female partners, as well as between these parties and the nurses in the Reproductive Health facilities, arising from negative perceptions, poor interpersonal relationships between stakeholders, the personal attributes of the male partners, the female partners and the nurses, in addition to certain socio-cultural barriers such as polygamy practices; myths about male involvement in the reproductive health; gender disparity; alcohol abuse by male partners, migratory labour and household duties. Poor partnerships could also be the result of a lack of knowledge and skills on the part of the agents (nurses), recipients (female and male partner) and other significant stakeholders in the Reproductive Health environment (Amukungo 2009, p.108)

It was further concluded that the context (environment) in which Reproductive Health services are delivered are not favourable in terms of the accessibility and utilisation of resources. It became clear that the Reproductive Health care delivery system does not facilitate male involvement in Reproductive Health. One of the reasons being that the difficulties clients both female and male experience in accessing facilities that provide Reproduction Health, namely the long distances involved and the unavailability of transport, the costs of Reproductive Health

treatment and the relatively lengthy periods spent by the female partners at facilities that provide Reproductive Health services (Amukungo 2009, p.108).

In addition, the study revealed that the way (process) in which nurses manage Reproductive Health services is inadequate owing to the unavailability and inadequacy of resources, policies and legislation, for management; a lack of management principles, as well as the unavailability and abuse of human and material resources to facilitate male involvement in Reproductive Health was also observed. Poor management was expressed in terms of inadequate buildings and poor infrastructure with regard to health facilities that are rendering Reproductive Health services; poor networking was also considered a problem (Amukungo 2009, p.110).

The findings of this study makes interesting reading for this researcher as the research did not take an interest in how the male partner got to know about the importance of their involvement in ante natal care, but only takes an interest in what happens at the health facility when the client is already there. This is because taking an interest in exactly what the male partner knew about ante natal or how they found out about the need to attend ante natal sessions would have given the study a good foundation.

2.6. Male Involvement in Bangladesh

Lessons were also learnt in a qualitative study conducted in Bangladesh in 2006 through focus group discussions to explore why men do not participate in reproductive health services. The findings of which indicated that men are not motivated and traditionally not encouraged to participate in reproductive health services. Other factors like poor husband-wife interaction which makes it difficult for men to understand reproductive problems of women, unmet 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 (Shahjahan, 2007, p.58).

2.7. Husbands involvement in maternal health in Guatemala

A study in rural Guatemala in 2002 also exploring Husbands' involvement in maternal health through individual interviews and focus group discussions reported a relatively desirable and unique involvement of husband in maternal health; however this is affected by factors like husband love for the wife, work demands, economic concerns and men's level of knowledge on maternal health (Carter, 2002, p.279).

2.8. Understanding barriers to male involvement in Nepal

A study in Kathmandu Nepal conducted in 2006 explored opinions of couples and health workers on the understanding on the barriers of male involvement in maternal health unfolded some of the barriers that prevent men from participating in maternal health include low level of knowledge, social stigma, shyness and embarrassment, job responsibility, space problem, non-couple friendly maternal health services and hospital policy restrictions. Furthermore, hospital policy restrictions, manpower and infrastructural problems are factors that have been known to impede men's participation in labour (Mullany, 2006, p.9).

CHAPTER THREE

3. METHODOLOGY

3.1. Research Design

This research applied the cross sectional design. This is because the researcher focused on more than one category (men and women) at a particular point in time or over a short period of time, Bryman (2012, p.58).

3.2. Research methods

This study used the mixed methods design or methodological triangulation method in gathering the data; that means the researcher applied both qualitative and quantitative methods. This is because the quantitative helped to answer ‘what’ numbers or percentages are involved while the qualitative helped to find reasons and other underlying factors. Thus the application of both methods complemented each other thereby giving a comprehensive view of the subject. By doing this, the research made a better evaluation and hence realised the objectives of the study.

3.3. Data Collection Methods

In the data collection, the researcher collected the data in two ways, namely; primary data collection and secondary data collection methods.

3.3.1. Primary Data Collection

In the primary data collection, the researcher used qualitative and quantitative methods. In the qualitative methods, the researcher used the Focus Group Discussions and In-depth interviews while in the quantitative methods the researcher used structured questionnaires.

3.3.1.1. Qualitative Methods

(i) Focus Group Discussions

Focus group discussions (FGD) were used to explore more details of the subject especially those that cannot be explained by statistics. The FDG also gives a useful insight by way of opinions and views from different people concerning the subject.

The researcher had two (2) FDG: one with the health workers working in the Maternal Child Health Clinic (MCH) at Chibefwe Health Centre and the other one with the Community Health Volunteers at Chalata Health Centre. This allowed the participants to agree or disagree with one another in the FDG while giving their own experiences concerning male involvement in ante natal care. The FDG also provided an arena for the range of ideas, beliefs and their experiences and practices in terms of communicating male involvement in ante natal care.

(ii) In-depth Interviews

The researcher used in-depth interviews method to gain a deeper understanding of the subject in the district. The interviews were open ended and the guides were not strictly followed because sometimes answers provided by respondents required probing to further explain emerging issues. Interviews were tape recorded with interviewee's consent. The researcher conducted interviews with the district maternal and child health coordinator, the nurse working in the MCH at Chalata Health Centre and also one Community Health Educator at Chibefwe Health Centre.

3.3.1.2. Quantitative Methods

Structured Interviews

The researcher used the structured interviews method also. The structured interviews were used because majority of the respondents were illiterate.

3.3.2. Secondary Data Collection

The researcher also used some books, journals and the internet to consolidate on the primary data that she collected. Document data collection is crucial for the purposes of reinforcing the primary data as well as the entire research so that there is more substance and evidence.

3.4. Study Site

The study was conducted at Chibefwe and Chalata Health Centres in Mkushi district of Central Province.

3.5. Study Population

The study population was the health personnel working in the MCH clinic and expectant mothers and their partners.

3.6. Sample Size

The researcher had a sample size of 50 expectant mothers and 50 male partners who were seeking health services from the health centres. In addition there were 10 health workers in the focus group discussions and in-depth interviews.

3.7. Sampling Technique

This research applied a non-probability sampling technique, specifically purposeful/ judgmental sampling. This is because the researcher knew the target group which could provide the required information. Pregnant women were purposively selected on ante natal clinic days for structured interviews. Each woman offered consent to participate and was privately interviewed in the clinic. For those who were accompanied by their partner, the partners were interviewed as well though separately. The couples were not together in order to minimize the risk of male partners influencing or restricting the women's ability to answer freely. Therefore the men interviewed in this study were not necessarily the partners of the women in the sample.

3.8. Data Analysis

The analysis of the data is crucial and extremely important because it is this analysis that gives value and meaning to the data that was collected. Since not all the information collected during the research may be useful for the study, so data analysis isolates useful data from irrelevant material.

The quantitative data collected was analysed using the statistical package for social science (SPSS) as it is quick and user friendly. This package was able to do calculations and provides diagrams such as bar charts and pie charts which were used in data interpretation. Content analysis was used to analyse the qualitative data that was collected. The choice of this tool was relevant especially when it came to recorded material and to classifying open ended responses to interviews and also in focus group discussions.

3.6 Ethical considerations

- **Informed consent** - : during the research, the researcher asked for permission and gave adequate information to all the participants in the research and they were made to understand what was involved in the study and consequently were able to make an informed, voluntary decision out of their own personal volition to participate in the study. All the participants in the study participated out of their own freewill; there was no manipulation or coercion whatsoever. The consent obtained was mainly verbal (oral).
- **Confidentiality:** the researcher made sure the privacy and identity of all the respondents was safeguarded. In order to ensure maximum privacy, anonymity and confidentiality, all the interviewees or respondents were assigned code numbers which were written on the questionnaires. The research findings are being published in a way that would not relate to the respondents.
- **Objectivity:** the researcher ensured that she remained focused without any biases, prejudices, spinning or manipulating the findings because such a thing would undermine the research findings.

- **Permission to conduct research:** authority to conduct research was obtained from the District Medical Officer who is the head of the institution (Mkushi community district medical office) well in advance.

3.7. Limitations of the study

The study had limitations in terms of not being able to do research on the topic in more rural health centres due to distance and the means of transport were not readily available. So the study picked on Chalata and Chibefwe Rural health centres due to their proximity to the Boma and were easy to reach. It is also important to mention that most respondents were not able to read and write, however this challenge was overcome by way of the researcher being able to interpret the questions in Bemba for easy understanding.

CHAPTER FOUR

4. CONCEPTUAL AND THEORETICAL FRAMEWORK

4.1. Introduction

In this study concepts and theories were examined as these determined how the subject matter was perceived and what aspects were emphasized. The concepts that were given much attention were male involvement, communication, ante natal care, promotion and strategies. These concepts provided the essential cornerstone for the study. The theories that were looked at in relation to the study were the diffusion of innovation theory and the multi- step flow of communication theory

4.2. CONCEPTUAL AND OPERATIONAL DEFINITIONS

4.2.1. Male Involvement

The understanding of the concept male involvement varies within the context in which it is used and its definition differs from literature to literature. Involvement refers to a process whereby an individual is actively engaged and is thus able to participate actively in, for example, the planning, organising, leading and implementing of a specific phase (American Heritage Dictionary, 2007a). According to Lee (1999, p.111) male involvement includes the following as part of the men's participation: attending women's health education sessions, attending counseling sessions and acting as community based volunteers. For Rutenburg et al., (2002,p.29-30), men's involvement may mean that men choose to come to the clinic with their partners, be counseled and get tested for HIV, support their partners in coping with HIV infection and support them financially or with transport to the clinic.

In this study male involvement entails:

- i. Initiating discussion about ante natal care issues with their partner
- ii. Providing information and support to the female partner
- iii. Alleviating the workload of female partner

- iv. Accompanying partner to ante natal clinic on all visits
- v. Making preparations for birth
- vi. Being aware of the health problems women suffer during pregnancy
- vii. Being aware of the critical pregnancy danger signs and what exactly to do about them

4.2.2. Ante natal care

According to the World Health Organisation (WHO), ante natal care also known as pre-natal care, is the complex of interventions that a pregnant woman receives from organized health care services. It also refers to the care that is provided to pregnant women from conception to onset of labour. These interventions may be provided in approximately 4 focused antenatal care visits during a pregnancy. WHO recommends that in these visits, interventions such as tetanus toxoid vaccination, screening and treatment of infections and identification of warning signs during pregnancy are carried out. The purpose of antenatal care is to prevent or identify and treat conditions that may threaten the health of the fetus/newborn and/or the mother, and to help a woman approach pregnancy and birth as positive experiences (<http://www.unicef.org/Zambia/51098457.html>, accessed on 1st December,2012).

According to the Global Health Observatory (2012, p. 2), globally, during the period 2005-2012, about 55% of pregnant women attended the recommended minimum four times ante natal care. The report also revealed that the proportion of pregnant women in developing countries who attended at least four ante natal care visits has increased from approximately 37% in 1990 to about 50% in 2011.

In this study ante natal care refers to the different interventions provided to an expectant mother from her first ante natal visit to the time just before delivery at a health centre.

4.2.3. Communication

A number of definitions have been made regarding communication. The attempts by different scholars in defining the term have led to there being no single approach to the study of

communication. Communication according to Elkamel (1986, p.12) is the exchange of ideas, information and opinions through speech, writing, pictures and other symbols. It is a sharing process where a source shares his or her messages with a receiver through a certain channel in order to influence the receiver's thoughts and actions. It is not a one way process but an exchange between the source and the receiver. According to Mefalopulos (2008, p.2) communication is the interactive process characterized by the exchange of ideas, information, points of view and experiences between persons and groups. This involves interpersonal communication, group communication and mass communication. It is generation of information and its dissemination and how this information affects individuals and communities.

Lievrouw (1993,p.8) on the other hand, gave a more comprehensive definition of the term communication by looking at it as, the process of sharing ideas, information and messages with others in a particular time and space – communication includes writing and talking, as well as non- verbal communication (such as facial expression, body language, or gestures), visual communication (the use of images or pictures such as painting, photos, video, or film), and electronic communication (telephone calls, electronic mail, cable television, radio, or satellite broadcasts).

Additionally, it is cardinal that communication campaigns are defined. According to Rogers and Storey (1987, p.817), communication campaigns are purposeful attempts to inform, persuade or motivate behavioral changes in a relatively well defined and large audience, generally for benefits to the individuals or society at large, typically within a given period of time by means of organized communication activities involving mass media and often complimented by interpersonal communication. Communication can take place at a more localized or community level involving activities which may include folk media, dance, plays and drama.

4.2.4. Participatory Communication

White (1994, p.12) defines participatory communication as a type of communication in which all interlocutors are free and have equal access to the means to express their point of view, feelings and emotions. In this study, participatory communication is operationalised to measure the full

participation of the expectant mother, expectant father, health service providers and others involved in the process of ante natal care in the community.

4.2.5. Mass Communication

This is the sending of messages from the source or originator to an audience which is large, heterogeneous and unorganized through a medium which could either be electronic or print. The former refers to Television, Radio and internet while the latter points to the Newspapers, Books and Magazines (Rogers 2003, p.8). Hartley (2002, p. 138) further defines it as the practice and product of providing leisure entertainment and information to an unknown audience by means of corporately financed, industrially produced, state-regulated, high tech, privately consumed commodities in the print, screen, audio and broadcast media, usually understood as newspapers, magazines, cinema, television, radio and advertising; sometimes including book publishing (especially popular fiction) and music (the pop industry). The application of this term in this study was to find out if at any point the District Community Medical Office promotes using media channels. The results of this application are more elaborated in chapter six.

4.2.6. Organizational communication

This is communication within an organization or between organizations (Gergen, Kenneth and Tojo, 1996, pp.803-813). The study investigated what and how the communication within the DCMO as an organisation is done. Further to also see how the DCMO communicates with other stakeholders especially concerning issues of promoting male involvement in ante natal care.

4.2.7. Importance of Communication

According to Infant at el., (1997, p. 23), it is important to communicate because it helps to create cooperation and interaction with one another, acquire information and entertain ourselves. He further explains that communication is important because without it development would not be possible. Even to be aware that development has occurred; one should be able to communicate within self (intra personal) and with others.

4.2.8. Communication Strategy

This is simply a set of communication procedures involving planned lines of action. A communication strategy is a well-planned series of actions aimed at achieving certain objectives or change through the role of communication methods, techniques and approaches (Mefalopoulos and Kamlongera, 2004, p.233). In this study, communication strategies refer to the different methods of communicating to improve on male involvement in ante natal care. This also implies looking at the messages that are being disseminated and the channels used to disseminate these messages.

4.3. THEORETICAL FRAMEWORK

4.3.1. Diffusion of Innovation Theory

Of utmost importance to this study is the diffusion theory. Diffusion is a process by which all innovations are communicated through certain channels overtime amongst members of a social system (Rogers, 1995, p.15). In this study, the spread of information on the importance of consistent male involvement in ante natal care was taken as a process of diffusion.

The key points in the process of diffusion can be identified as:

1. An innovation is an ideal practice or object that is perceived as new by an individual or unit of adoption. In this study, the need for male partner participation in ante natal care was taken as an innovation.
2. An individual or other unit of adoption that has the knowledge or experience with using the innovation. The study was interested to find out the levels of knowledge or experience by the health care providers and women that have benefited from their spouses participating in ante natal care.
3. Another individual or unit that does not have the knowledge or experience with the innovation. This study tried to identify expectant mothers and fathers in the community who did not have the knowledge or experience of having their spouses involved in ante natal care.
4. The communication channel linking the two individuals above. This study looked at the communication channels linking the two groups above.

During the diffusion of an innovation, the process of adoption is broken down into five stages.

The five stages are:

- i. Awareness
- ii. Interest
- iii. Evaluation
- iv. Trial
- v. Adoption

The theory also discusses the innovation decision process; this process also has five stages:

- i. From first knowledge of innovation
- ii. To forming an attitude towards the innovation
- iii. To a decision to adopt or reject,
- iv. To implementation of the new idea
- v. To confirmation of this decision

Rogers (1995, p.17) also explains that it should be noted that prior conditions affect the innovation–decision process. Prior conditions such as:

- i. Previous practice
- ii. Felt needs/problems
- iii. Innovativeness
- iv. Norms of the social system

Relevancy of the theory to the study

Rogers's theory is of great importance to this study because it helps us to understand the processes that people go through before they can adopt a new idea, in this case male involvement in ante natal care. Therefore, when coming up with messages of male involvement, the medical office should focus their effort on creating awareness and knowledge in the process of promoting male involvement in ante natal care. The process of diffusion requires reinforcing the dissemination of messages as people have different rates of adoption. This process is of great

importance because behavioural change can only come about if there is a constant flow of information.

The theory is also relevant because it reinforces the argument that people take on new ideas at different intervals (rate of adoption). As a new idea comes up in the community, some members of the community will adopt it faster than others depending on different factors such as relative advantage, compatibility with the culture and norms in that particular society, triability of the innovation and observability (ability for people to see and learn lessons from the success or failure of an innovation). So in this case if men are informed and involved from the beginning they provide better support for their female partners but however the adoption of new programs by recipients is influenced by knowledge and awareness.

4.3.2. The Multi step flow of communication

This theory was propounded by sociologists called Paul Larzarfeld and Elihu Katz .This theory asserts that information from the media gets to opinion leaders before being disseminated to a wider population. First, individuals (opinion leaders) who pay close attention to the mass media and its messages receive the information. Opinion leaders pass on their own interpretations in addition to the actual media content. The term ‘personal influence’ was coined to refer to the process intervening between the media’s direct message and the audience’s ultimate reaction to that message. Opinion leaders are quite influential in getting people to change their attitudes and behaviours and are quite similar to those they influence (www.sonamjournoblogspot.com/, accessed on 18th February, 2014).

The multi-step flow theory has improved the understanding of how the mass media influence decision making. The theory argues that opinion leaders intervene between the media’s direct message and the audience’s reaction to that message. Opinion leaders tend to have a great effect on those they are most similar to - based on personality, interests, demographics or socio-economic factors. These leaders tend to influence others to change their attitudes and behaviours more quickly than conventional media because the audience is able to better identify or relate to an opinion leader than an article in a newspaper or news program,

(www.sonamjournoblogspot.com/, accessed on 18th February, 2014). The theory refined the ability to predict the influence of media messages on audience behaviour, and it helped explain why certain media campaigns may have failed to alter audience attitudes and behaviour.

Relevance of the theory to the study

In this study, the theory was used to see the role opinion leaders like traditional leaders and other prominent people in the community play in encouraging male involvement in ante natal care, the messages and communication channels that are used. It also helped to see how influential these opinion leaders are in changing people's attitude and behaviours. In Mkushi District, it is evident that the traditional leaders have an influence on the community. Community leaders are being incorporated through the Campaign on Accelerated Reduction of Maternal Mortality (CARMMA). Meetings are being held with community leaders sensitizing on male involvement and the need to reduce maternal mortality in the community. The objectives of these CARMMA community meetings are the following:

- i. To sensitize traditional leaders and their chiefdoms on male involvement and safe motherhood.
- ii. To come up with traditional laws that will help to safeguard the life of women in the community as regards to safe motherhood.
- iii. To introduce the programme of the Safe Motherhood Action Groups in order to be sensitizing the community members on safe motherhood

The district medical office was using traditional leaders as change agents as they were encouraging them to come up with laws that encourage male involvement in ante natal care. The district office was also encouraging the traditional leaders (opinion leaders) to work together with the Safe Motherhood Action Groups (SMAGs).

CHAPTER FIVE

5. PRESENTATION OF FINDINGS

5. 1. Introduction

This chapter discusses the findings of the data that was collected through quantitative and qualitative surveys during the attachment with the Mkushi District Medical Office. The study evaluated communication strategies used by the Mkushi district medical office in promoting male involvement in ante natal care.

The chapter is divided in two parts: the first part presents findings from the quantitative survey and gives more information on the knowledge levels of the people in the community and also their information sources. The second part of the chapter presents the qualitative data and examines the different themes that emerged. This part of the chapter goes deeper to bring out individual, health providers and community diverse narratives and views on male involvement in ante natal care in Mkushi district. In presenting both quantitative and qualitative findings, pie charts, pictures and tables have been used for clear interpretation of the data.

5.1.1. Quantitative survey findings

The quantitative findings begin with a brief background of the respondents and then goes on to more rigorous statistical data on findings from this study.

5.1.2. Background of the respondents

The study had a sample size of 100 but only 92 questionnaires were answered. Therefore, the valid number of questionnaires was 92. 42 questionnaires were administered to the fathers while 50 were administered to the expecting mothers, so in this case sex is not a distinct variable as a specific number of questionnaires were designated for each sex and had different questions.

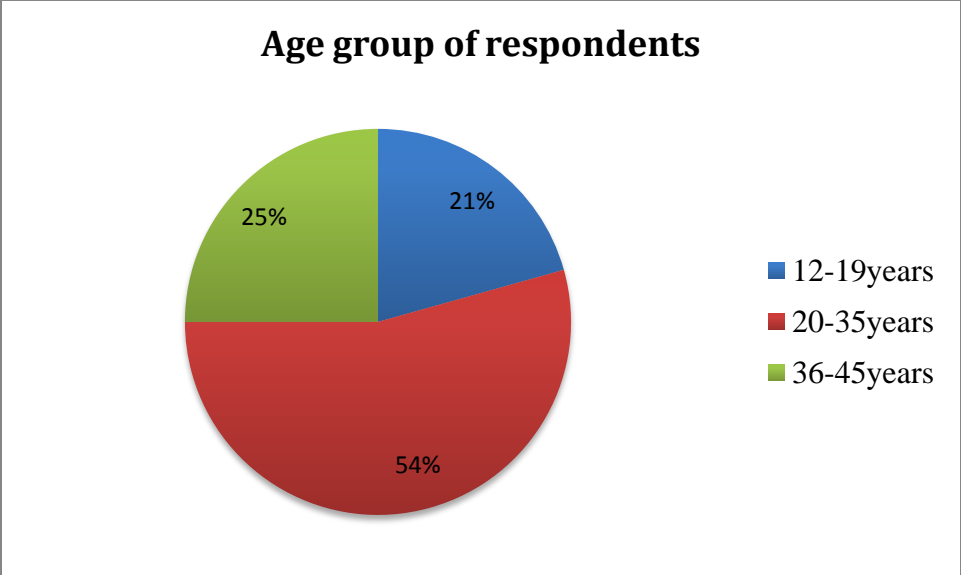


Figure 5.1 Age of respondents

The age range of the respondents was 12 to 45 years. The majority of the respondents (54%) were in the age range of 20-35 while 25% were in the range of 36-45 years and the minority (21%) were from the age range of 12-19. The majority of the respondents being in the age range of 20-35 reveal the fact that this is the highest reproductive age group.

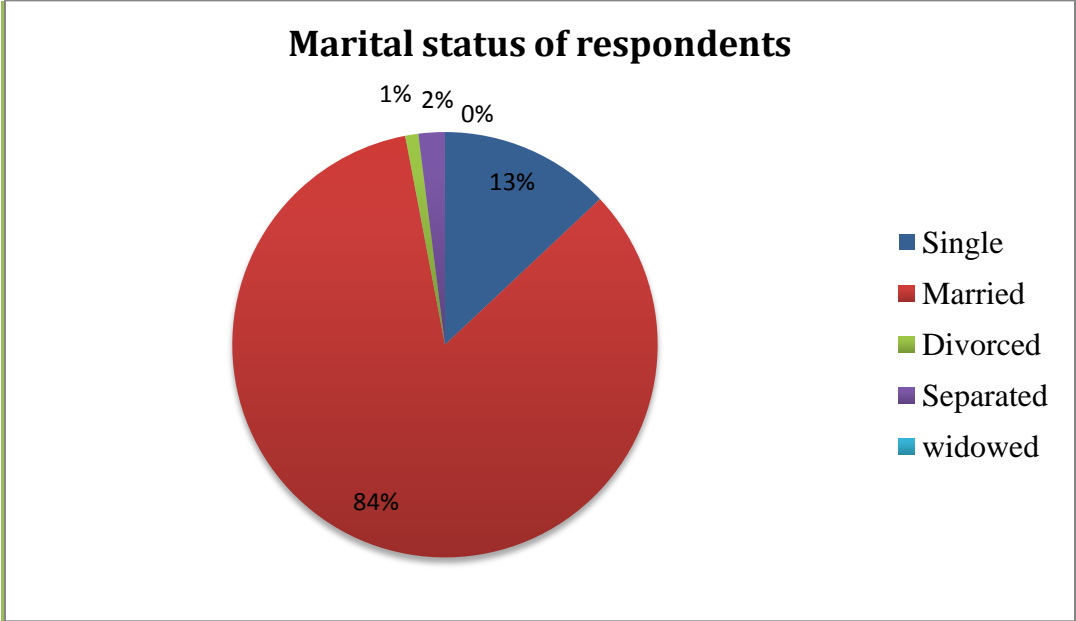


Figure 5.2 Marital Status of respondents

As shown in figure 5.2, the majority of the respondents were married, this accounted for 84% of the sample size and 13% of the respondents were single. 1% of the respondents were divorced while 2% were separated.

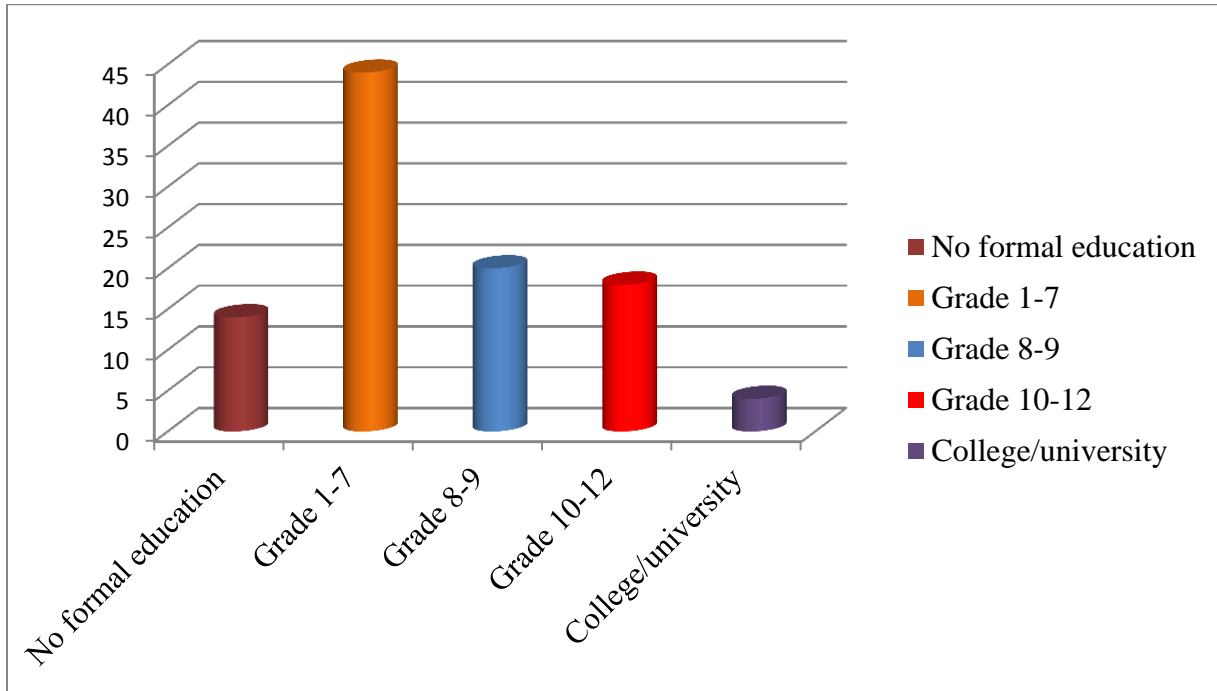


Figure 5.3 Educational level of respondents

The majority of the respondents indicated their educational level as being in the range of grade 1 to 7 represented by 44% followed by those in the range of grade 8 to 9 at 20% then grade 10 to 12 was 18%. At 14% were respondents with no formal education and 4% said they had been to college. The level of education was assessed to help the research see if this had an impact on how they communicate with health providers and how they receive information on male involvement.

Table 5.1 Ability to read and gender

Ability to read and gender						
Educational level	Expecting mother		Fathers		Total	
	Yes	No	Yes	No	Yes	No
No formal education	0	8	1	4	1	12
Grade 1 to 7	0	26	1	13	1	39
Grade 8 to 9	7	0	11	-	18	-
Grade 10 to 12	6	0	11	-	17	-
College	3	0	1	-	4	-
University	0	0	0	-	0	-
Total	16	34	25	17	41	51

Table 5.1 shows gender and ability to read. It reveals that there are more fathers who are able to read compared to the expecting mothers. 25 of the fathers said they were able to read while 16 of the expecting mothers said yes they were able to read. This information is important to this research as it reveals the percentage of respondents who had direct access to print media and also those that had no direct access to print media. From the table, the data reveals that 34 out of 50 expecting mothers were not able to read and 17 out of 42 fathers were not able to read. It is clear from the table that the majority of respondents were not able to read and therefore majority did not have access to print media.

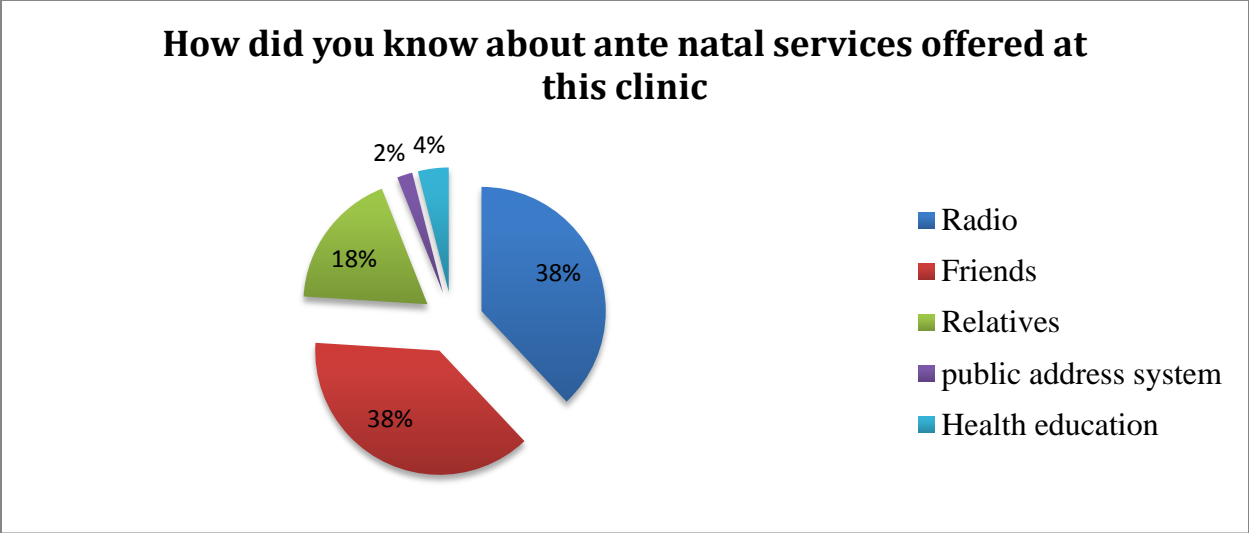


Figure 5.4 Source of information about ante natal services

In this study, the expecting mothers when asked how they knew about ante natal services offered at the health centres, 38% said from the radio and another 38% said from friends. The remaining 18%, 4% and 2% said from relatives, from health education sessions at the health centre and from public address system respectively. As the results show from figure 5.5 the majority of the respondents were more in contact with radio and friends and that’s where they got information about the ante natal services offered at the health centre. Therefore, it was imperative that the health centre through the district medical office identifies opinion leaders; these could be traditional leaders or community leaders from different walks of life to work in conjunction with the Health Centre in sensitizing the community through community radio on ante natal care services in general and male involvement as an important component of it.

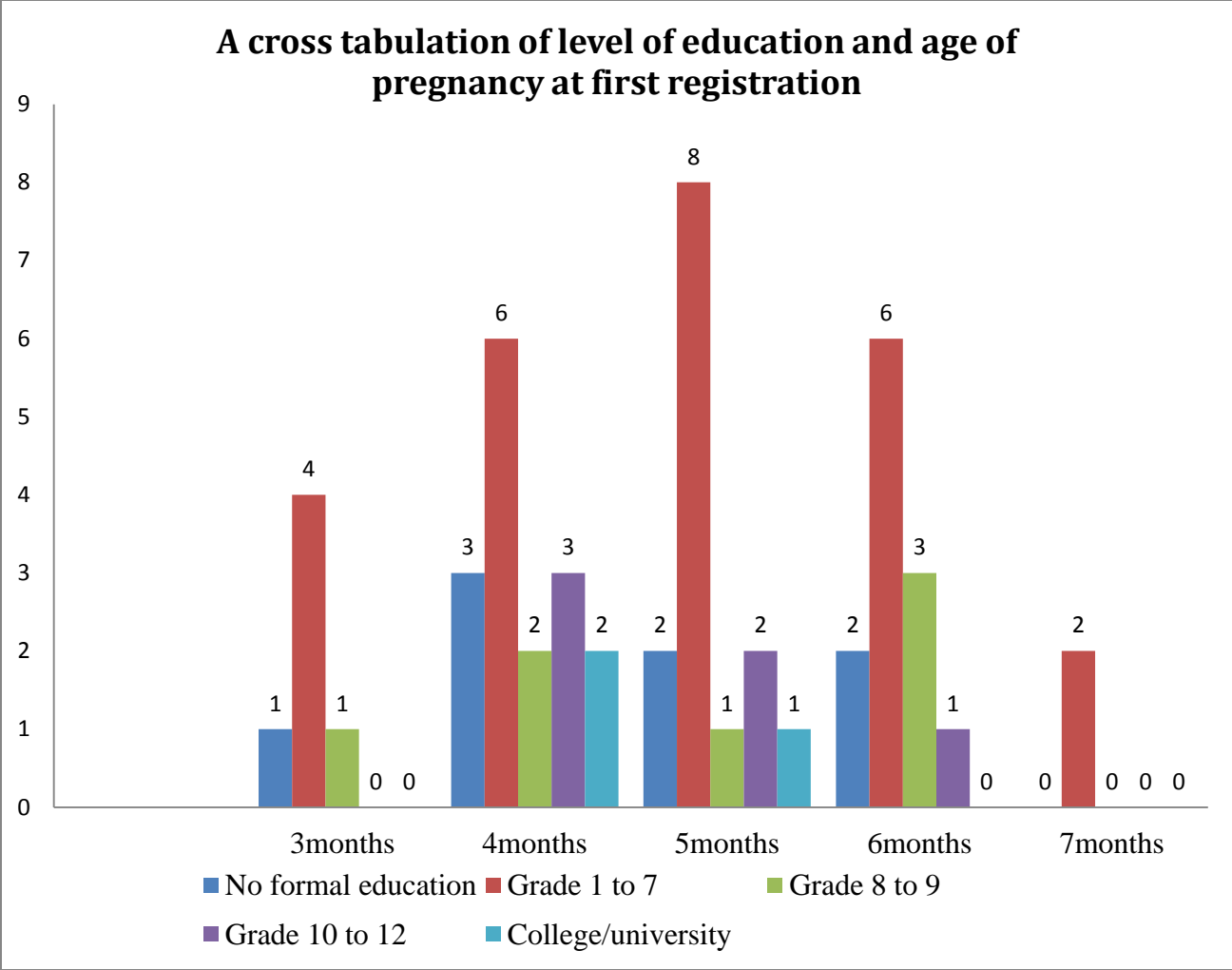


Figure 5.5 Education level and age of pregnancy at first registration

Figure 5.5 shows a comparison of the level of education and the age of pregnancy at first registration. This was to determine whether the level of education of women has a bearing on their being able to register early enough and in the long run involve their partner early in their ante natal. Looking at the results, it is clear that the level of education does not have a direct bearing on whether a woman will register for ante natal early as even the least educated registered early in their pregnancy.

Out of the fifty (50) expecting women questioned only 6 registered at 3months of pregnancy, 16 women registered at 4months, 14 registered at 5months, 12 registered at 6months and 2 registered at 7months. Out of the 6 that registered at 3months, 4 were in the category of grade 1

to 7 level of education, 1 had no formal education and 1 was in the category of grade 8 to 9 this shows that the high level of education does not necessarily mean that the woman will register early for ante natal. Early registration of ante natal is important as it enables male involvement to be effective in that the earlier the woman registers for ante natal the earlier the man gets involved in the process of safe motherhood.

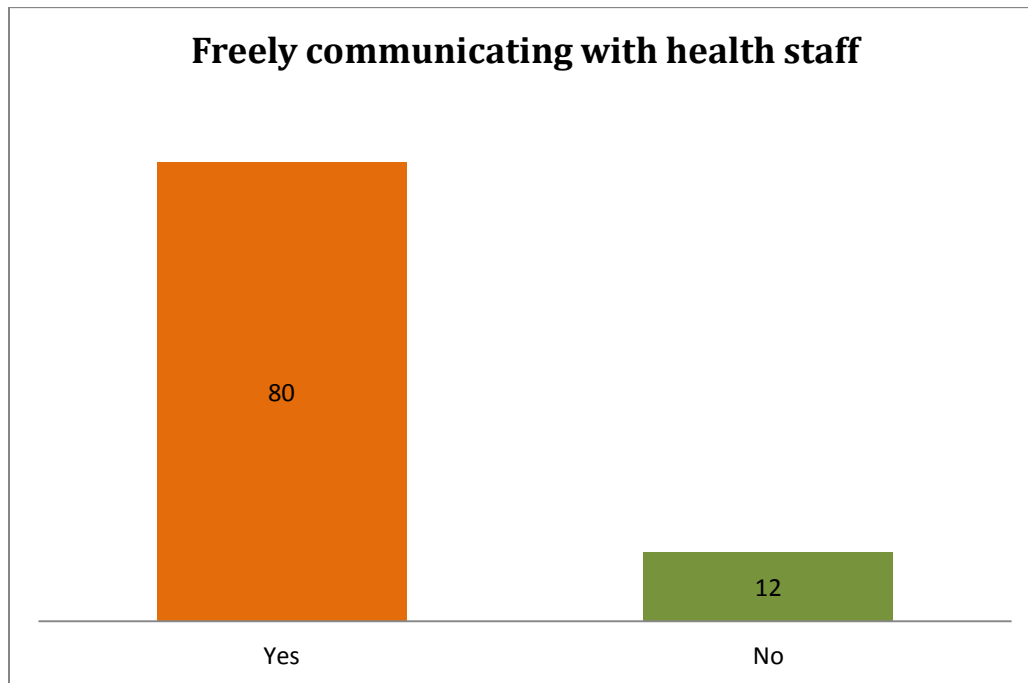


Figure 5.6 Ability to freely communicate with the health providers

Out of 92 respondents a total of 80 said they were able to freely communicate with the health providers while 12 said they were not able to communicate freely, the respondents who said that they were not able to communicate freely gave their reasons; these reasons are tabulated below in the chart.

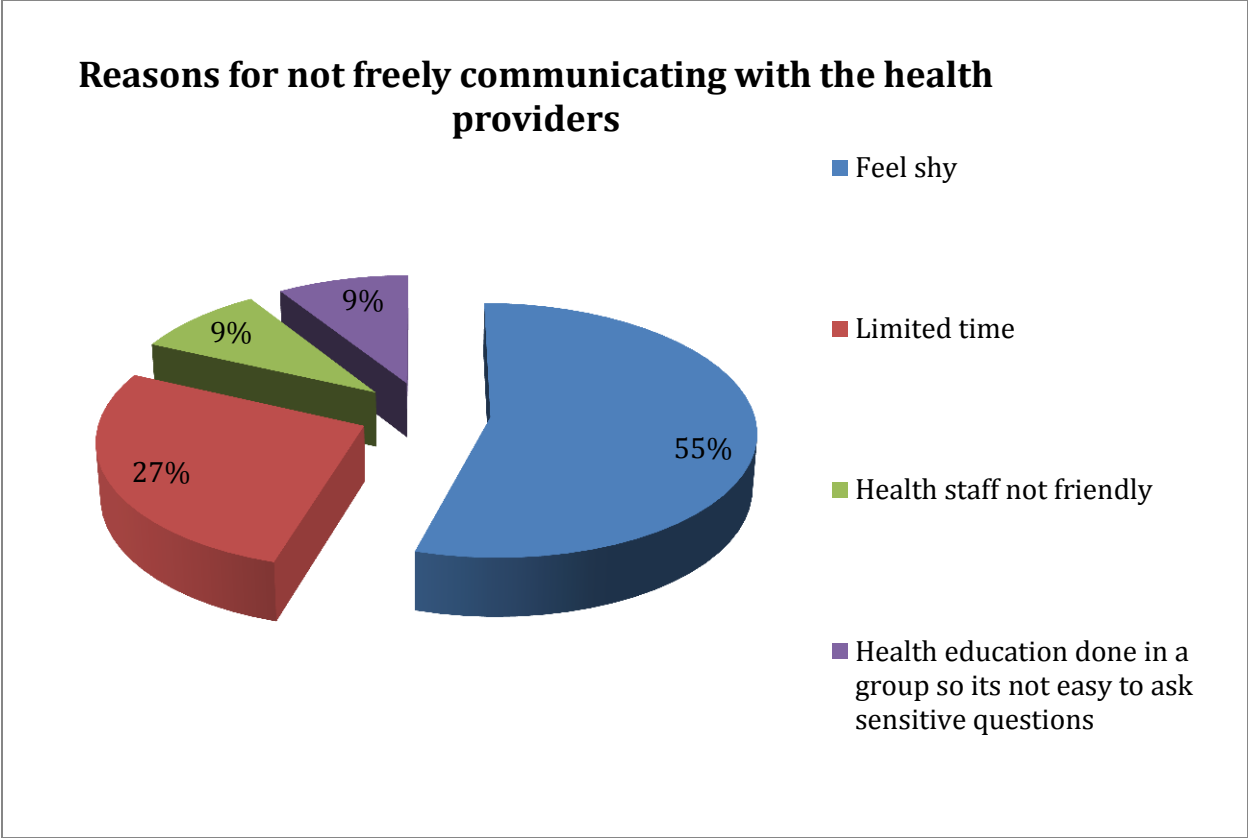


Figure 5.7 Reasons for not freely communicating with the health providers

Of those that said they did not freely communicate with the nursing staff, 55% said they felt shy while 27% said limited time for the ante natal sessions and 9% each said health staffs were not friendly and health education sessions were done in a group so it’s not easy to ask sensitive questions in order to get adequate information.

A question was posed to the expecting mothers, whether they think their partners should accompany them to ante natal, 98% said yes and only 2% said no. This is clear evidence that the women in this community have appreciated male involvement in ante natal care. The pie chart that follows shows the results:

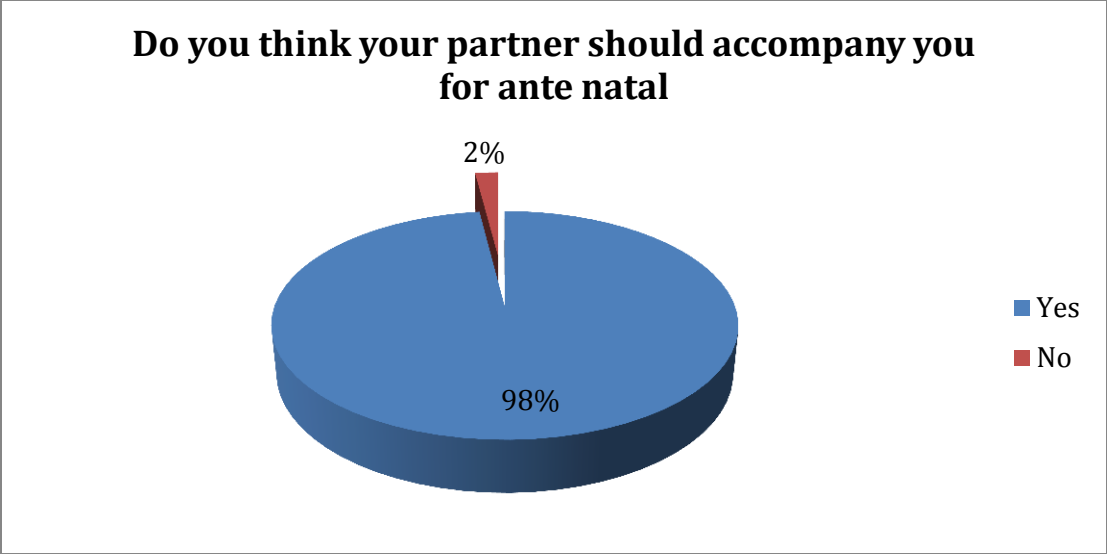


Figure 5.8 Do you think your partner should accompany you for ante natal

Of those that said yes the majority expressed views that when their partners were involved there was increased communication between the couple. They also indicated that it provided an opportunity for the man to learn about the health condition of the mother and baby. So when they were educated as a couple they turned to gain a lot of information which benefitted the family. A randomised control study with a large sample size of 442 women attending antenatal clinic in one of the hospitals in Kathmandu in Nepal, concluded that women learnt and retained most of the information when they were educated with their partners (Mullany, 2006, p. 13).

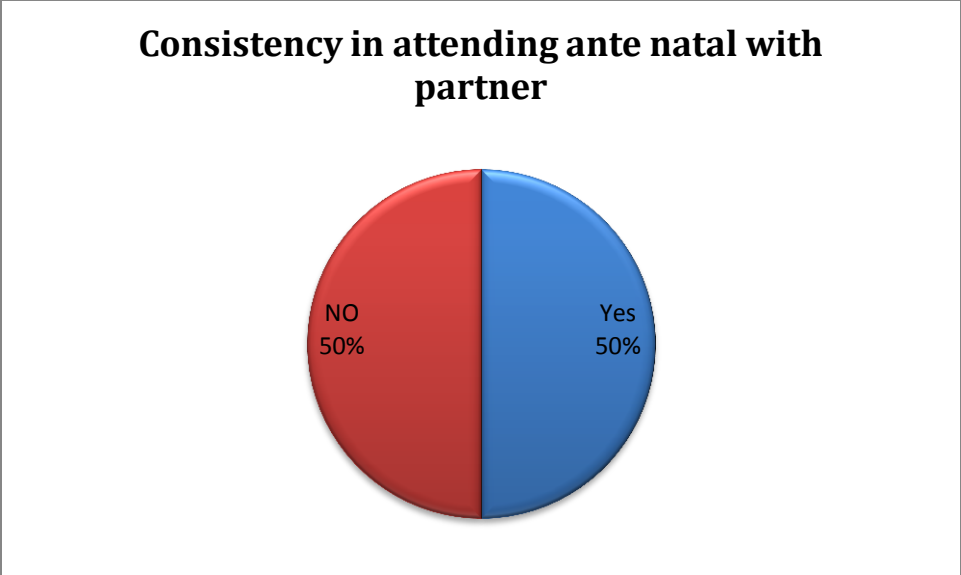


Figure 5.9 Consistency in attending ante natal with partner

When asked if the respondents had been attending ante natal consistently with their partners, 50% of the respondents said yes and 50% no to the question. On this question the research could not ascertain the validity of the answers given as she had no means to do so but instead depended on the hope that the respondents were being truthful.

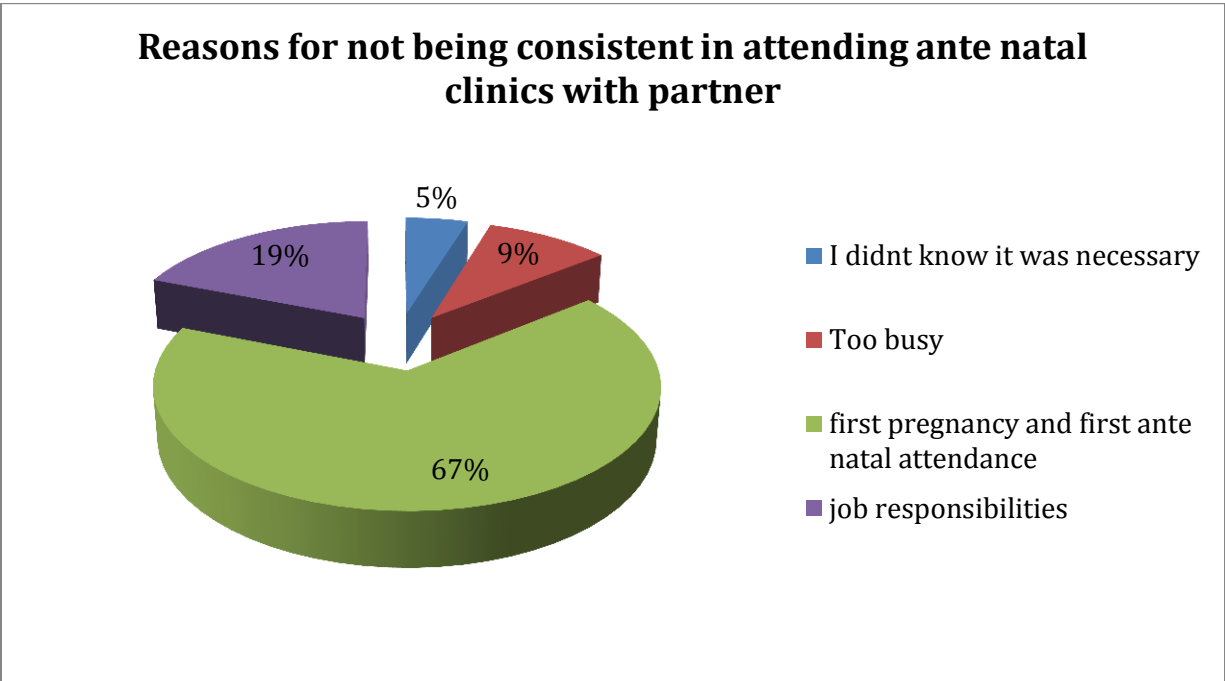


Figure 5.10 Reasons for inconsistency in attending ante natal with partner

Figure 5.10 shows the reasons why 50% said no to consistently attending ante natal clinics with their partner. 67% of the respondents said it was their first pregnancy and first ante natal attendance, so in terms of consistency it didn't apply because it was their first attendance. 19% said due to job responsibilities their partners were not able to attend ante natal with them, this is because their employers did not give them permission off work. Some respondents indicated having a limited income and needed many hours of work to meet all their needs. 9% said they were too busy with other things like business and farm work. Mkushi being a farming area entails that a good percentage of both men and women were farm workers and some farms paid according to the number of hours a worker puts in, a respondent mentioned that absence from work even for an hour reduced his monthly pay, but he sometimes had to sacrifice just to attend ante natal clinic. 5% of the respondents said their partners said they didn't know it was necessary to attend ante natal with their spouses. So this figure shows some of the reasons cited by the respondents on their lack of consistency in attending ante natal with partner.

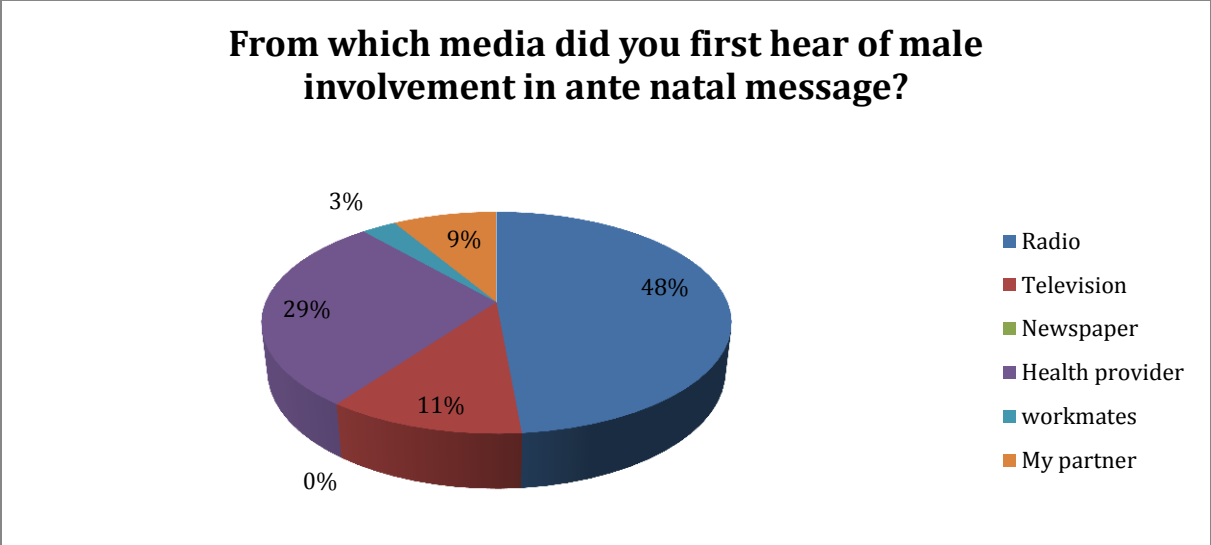


Figure 5.11 Medium you first heard male involvement in ante natal care

Figure 5.11 shows percentages of respondents according to the medium they first heard the message of male involvement in ante natal care. It was important to establish through which media respondents first heard of male involvement, this is because the first time someone comes in contact with information determines their perception and attitude towards a particular thing. The way a message is put across also has a bearing on how it is received

From this investigation, 48% said they first heard the message through the radio, while 29% said through a health provider, 11% said through television, those that said through television further mentioned that they first heard about it on a program called “Your health matters” broadcasted on the Zambia National Broadcasting Corporation television on a slot allocated during the main news bulletin. 9% said through their partner and another 3% said through workmates. This reveals that the radio was an effective tool to use in communicating with men concerning their involvement in ante natal care especially in the Mkushi community.

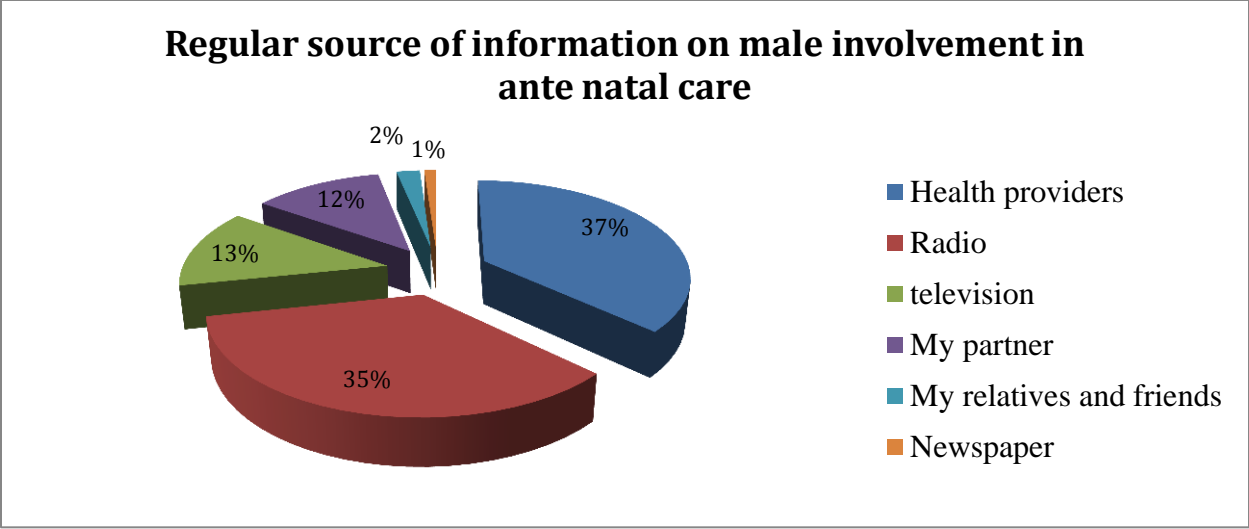


Figure 5.12 Regular source of information on male involvement in ante natal care

Having looked at where the respondents first heard the message of male involvement in ante natal care, the research now looks at their regular source of information concerning male involvement in ante natal care. Figure 5.12 shows the respondents’ regular source of information on male involvement in ante natal care. 37% of the respondents said their regular source of information were the health providers who at regular intervals talked about male involvement each time they gave out health talks both in the community and at the health centre. 35% of the respondents said they got their information through the radio and they further mentioned that the radio station they listened to was Mkushi Radio which is a community radio station. 13% of the respondents said they got their information on television through a program called “Your health matters”. 12% especially the men said they got the information on male involvement in ante natal care through their partners, 2% said through relatives and friends while 1% said through the newspapers. The low percentage of those who got information through the newspapers can be explained by the low literacy levels among the respondents.

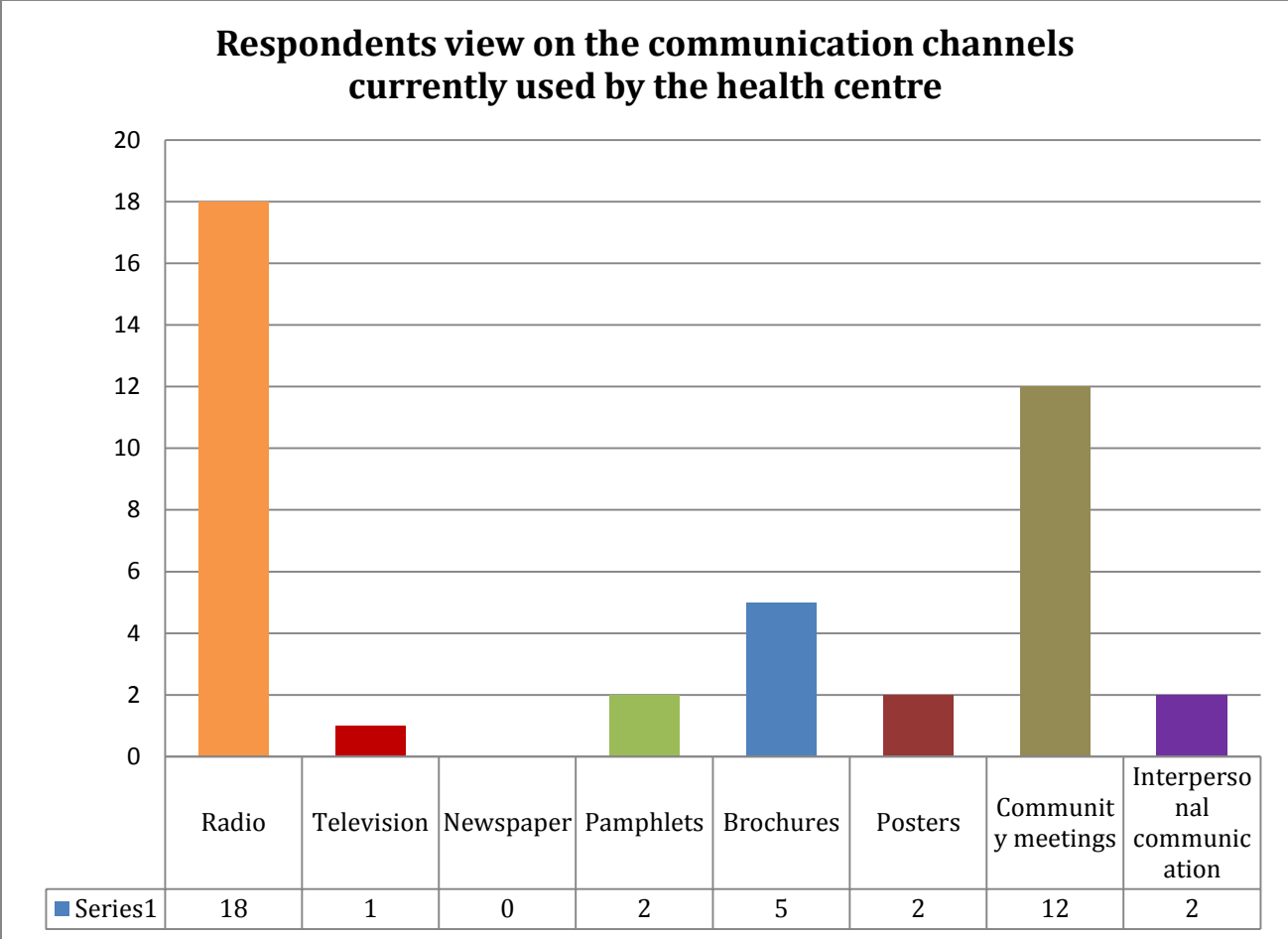


Figure 5.13 Channel through which the health centre disseminates information to the community (expecting fathers)

Majority of the expecting fathers said the type of communication was through the radio represented by 18 followed by those who said group communication at 12. The remaining types of communication selected have figures ranging from 5, 2 and 1 which are brochures, pamphlets, posters, interpersonal communication and television respectively.

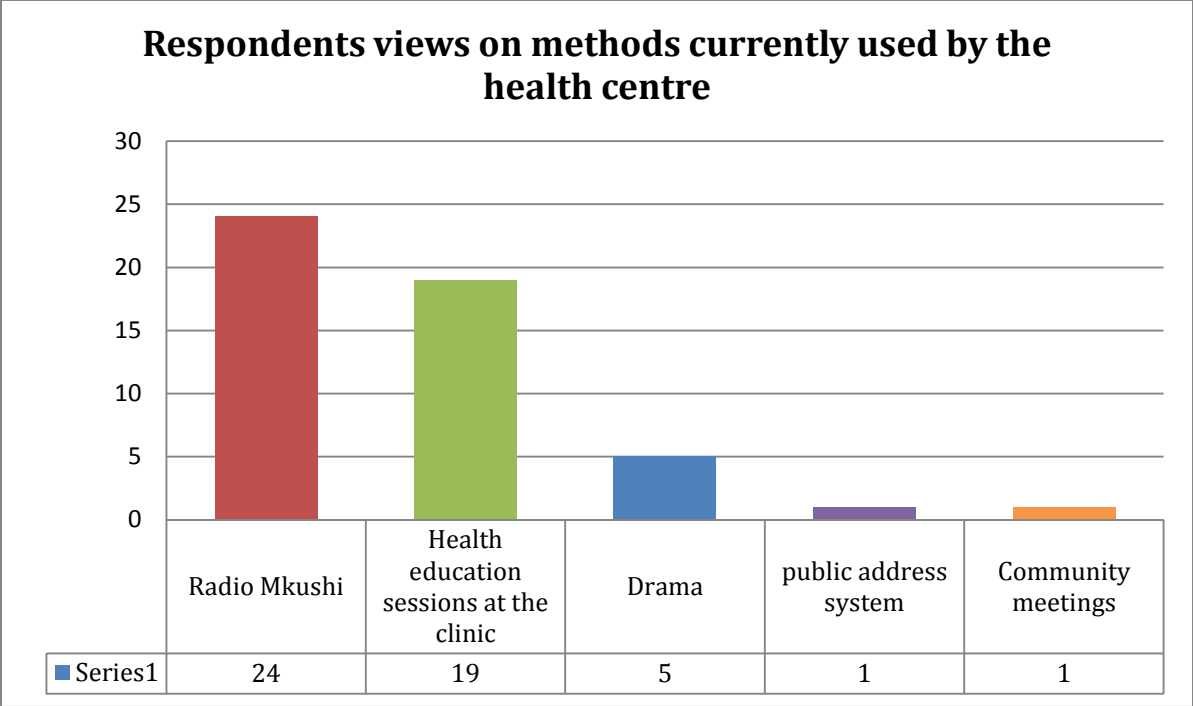


Figure 5.14 Channel through which the health centre disseminate information to the community (expecting mothers)

Figure 5.16 shows that expecting mothers like fathers also had a similar outcome with majority saying that the channel through which information was received from the health centre was radio represented by 24 (though the expecting mothers specified the type of radio as being radio Mkushi). Those who said health education sessions at the clinic were 19 then 5 said drama and 1 each said public address system and community meetings.

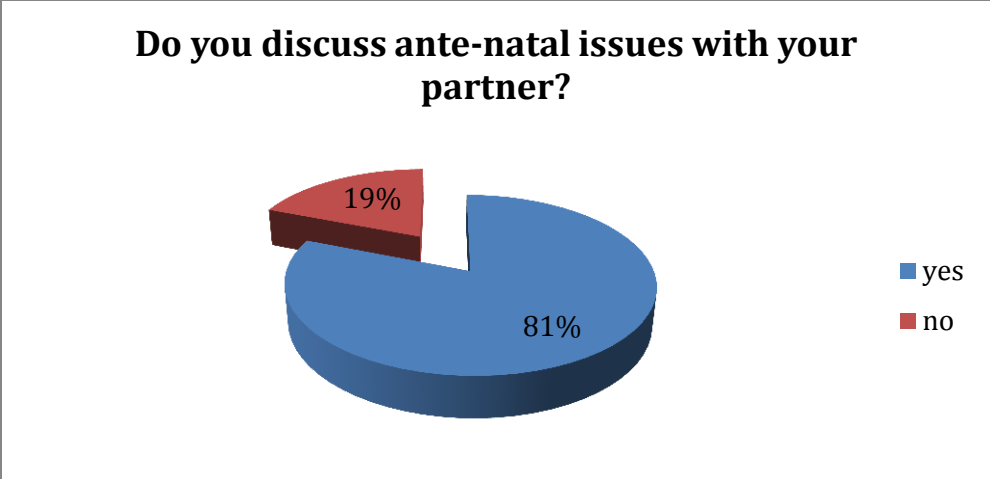


Figure 5.15 Discussing ante natal issues with partner

When the respondents were asked if they discussed ante natal issues with their partners 81% of the respondents said they discussed ante natal issues while 19% said they had not discussed ante natal issues with their partners. Investigating to see if couples discussed ante natal issues was of importance to this research because decision making and care seeking as a process facilitates good family reproductive health.

Table 5.2 Perception of male involvement in ante natal and knowledge

Perception of male involvement in ante natal and knowledge?		
Perception of male involvement in ante-natal care?	Knowledge to accompany your partner for ante-natal is mandatory	
	Yes	No
It's a good program though most men find it difficult as they are busy most of the time with work	2	1
Gives me information I need to take care of my partner during pregnancy	10	0
Good program encouraging men to learn more about pregnancy danger signs	6	1
program to get men fully involved in their partner's pregnancy	10	1
Encourages couple health communication	5	0
Good program for the prevention of mother to child transmission	6	0
Total	39	3

When the expecting fathers were asked about their perception of male involvement in ante natal care; 10 said it gave them information they needed to take care of their partners during pregnancy and 11 said the program helped get men fully involved in their partner's pregnancy. 7 said the program encouraged men to learn more about pregnancy danger signs and 6 said it was for the prevention of mother to child transmission of HIV. 5 said it encouraged couple health communication. Out of the 42 respondents that responded to the questionnaires, 39 said they knew they needed to attend ante natal while 3 said they didn't know at all until they were recently summoned by the health centre.

A person's perceptions of another person may exert an influence on the way in which a person either accepts or rejects a certain situation (Hugh & Foley 2007, p54). It is said that these perceptions allow the individual to select, organise and interpret a situation to form a meaningful picture of the world. From the above responses it is clear that men were aware and realize the importance of their involvement and were willing to take responsibility of the wellbeing of their families. They were also clearly aware of the benefits of their involvement in ante natal even though there was still lack of communication and openness between couples. Men clearly had an idea of what male involvement was all about.

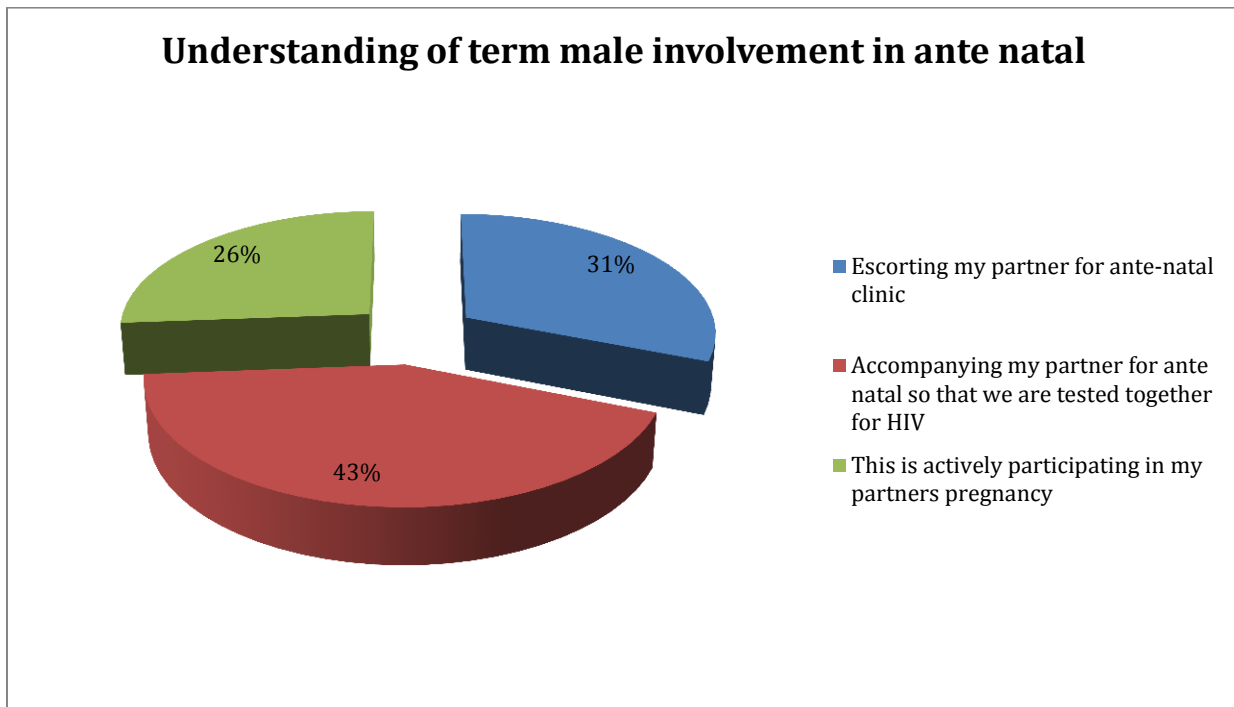


Figure 5.15 Understanding male involvement in ante natal care

The respondents (expecting fathers) were asked on their understanding of the term male involvement in ante natal care. In this research, it was important to find out the men's understanding of male involvement as this helped gauge their involvement. It is however sad to note that 43% of the men said male involvement was accompanying their partner for ante natal so that they can get tested together for HIV. So for this percentage of men, they think male involvement is all about Prevention of Mother to Child Transmission (PMTCT), this is not the case as male involvement in ante natal care is a package which comprises several components and PMTCT is only a component of the program and not the only essence of the program. 31%

of the respondents defined male involvement as escorting their partner for ante natal session. The implication with this response is that it isolates and alienates them from the process and only leaves the men as observers rather than participants in the process.

Table 5.3 Importance of male involvement in ante natal care

What do you think is the importance of men's involvement in ante natal care?								
What do you think is the importance of male involvement in ante-natal care?	12-19years		20-35years		36-45years		Total	
	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
Couple HIV counseling and testing	4	16.00%	18	72.00%		12.00%	25	100.00%
Helps the couple to prepare adequately for their unborn child	1	11.10%	6	66.70%		22.20%	9	100.00%
Educates men about their partners pregnancy thereby avoiding maternal deaths	1	25.00%	2	50.00%		25.00%	4	100.00%
Prevention of mother to child transmission	1	33.30%	0	0.00%		66.70%	3	100.00%
Total	7	17.10%	26	63.40%		19.50%	41	100.00%

Table 5.3 shows the responses from fathers regarding what they thought about the importance of men's involvement in ante natal care. 25 respondents said couple HIV counselling and testing makes men's involvement in ante natal care important while 9 respondents said it helped the couple to prepare adequately for their unborn child. 4 said it educated men about their partner's pregnancy thereby avoiding maternal deaths and 3 said prevention of mother to child transmission was enabled.

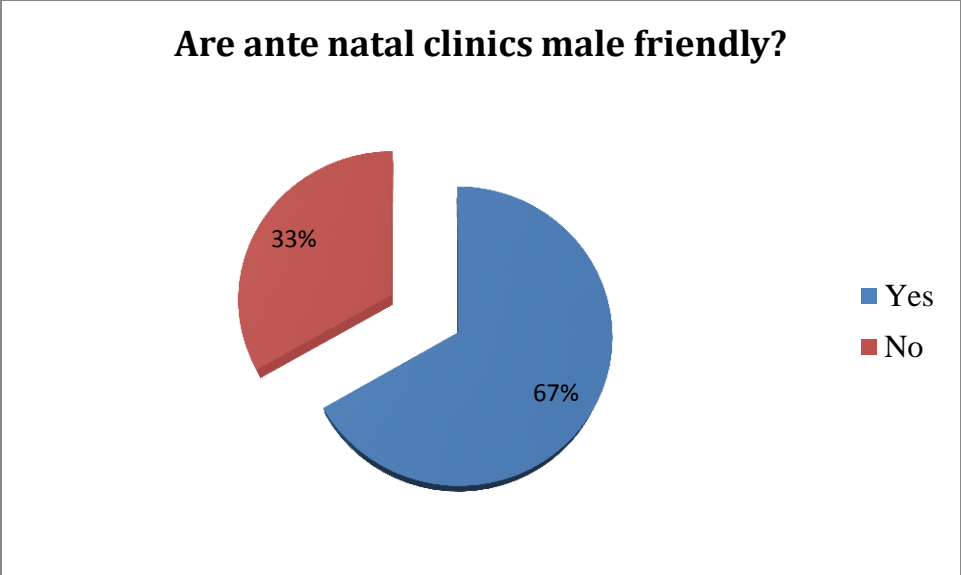


Figure 5.16 Male friendly clinics

Majority of the men when asked if they thought ante natal clinics were male friendly said yes represented by 67% and those who said no were at 33%.

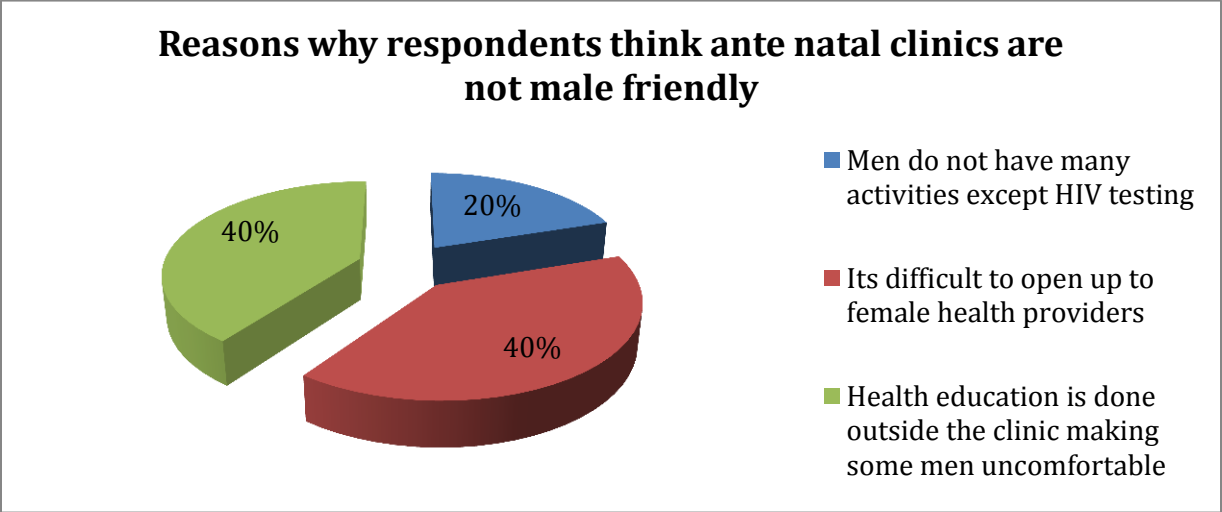


Figure 5.17 Respondents reasons ante natal clinics are not male friendly

Figure 5.17 shows in percentage the 14 respondents who said their reasons for saying ante natal clinics are not male friendly. Figure 5.17 shows that 40% of the respondents each gave reasons saying health education was done outside the health centre making them uncomfortable and another 40% said it was difficult to open up to female health providers and suggested that the centre could also have male health providers. 20% gave the reason saying men did not have many activities except HIV testing.

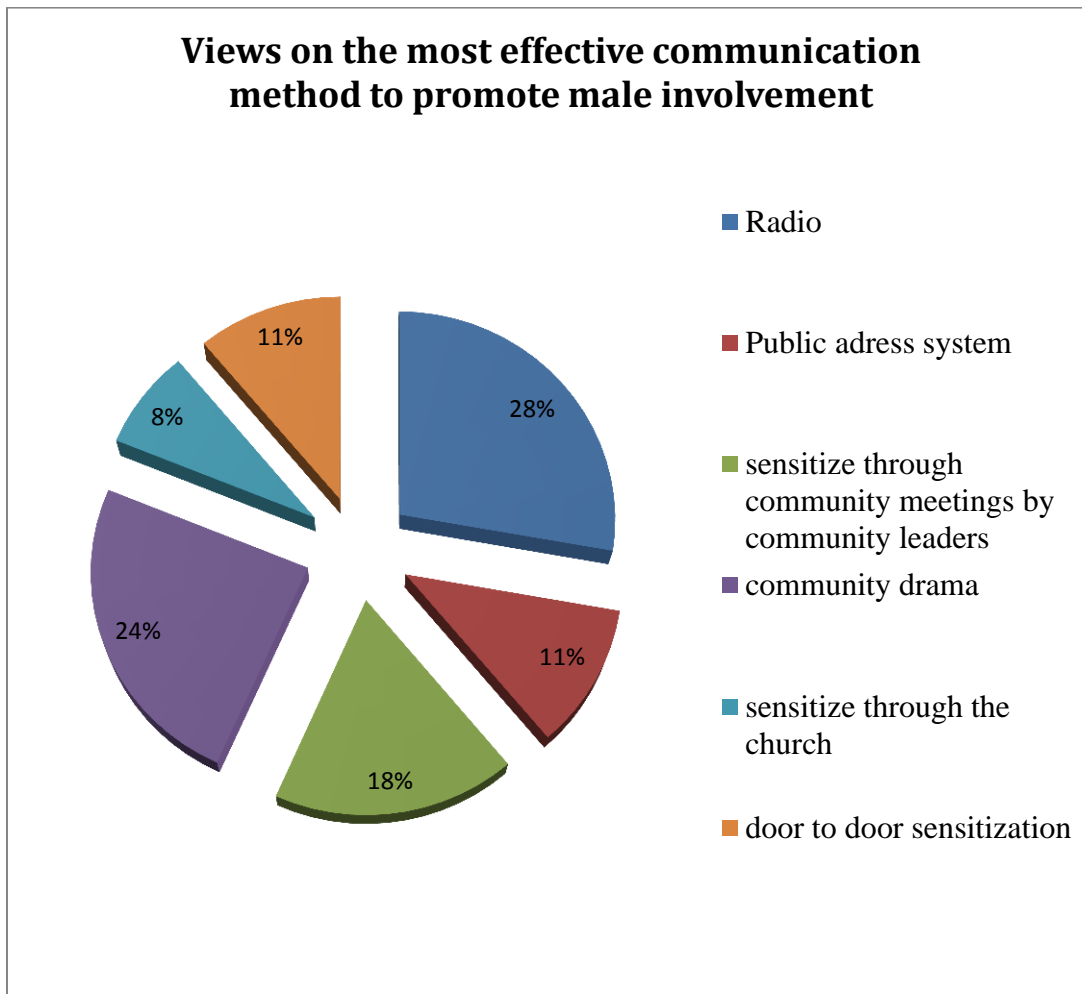


Figure 5.18 Effective communication methods to promote male involvement in this community

The majority of the respondents' perception regarding the most effective communication method to be used by the district medical office in promoting male involvement in ante natal care in Mkushi as shown in figure 5.18 was that the radio was thought to be the most effective communication strategy followed by community drama with 12 and 10 respectively. 8 of the respondents thought that sensitization through community and traditional leaders would be the most effective while 6 said the effective communication strategy was door to door sensitization while 5 said using public address system and only 1 person said sensitize through the church.

In addition another effective method suggested by the respondents in order to encourage husbands to accompany their wives for ante natal care is that when those expecting mothers come with their husbands, the centre attended to them as first priority. In doing so the expectation was that the expecting mothers who came without their husbands would be encouraged to come with their husbands.

What do you think must be done by this clinic to encourage male involvement in ante natal care

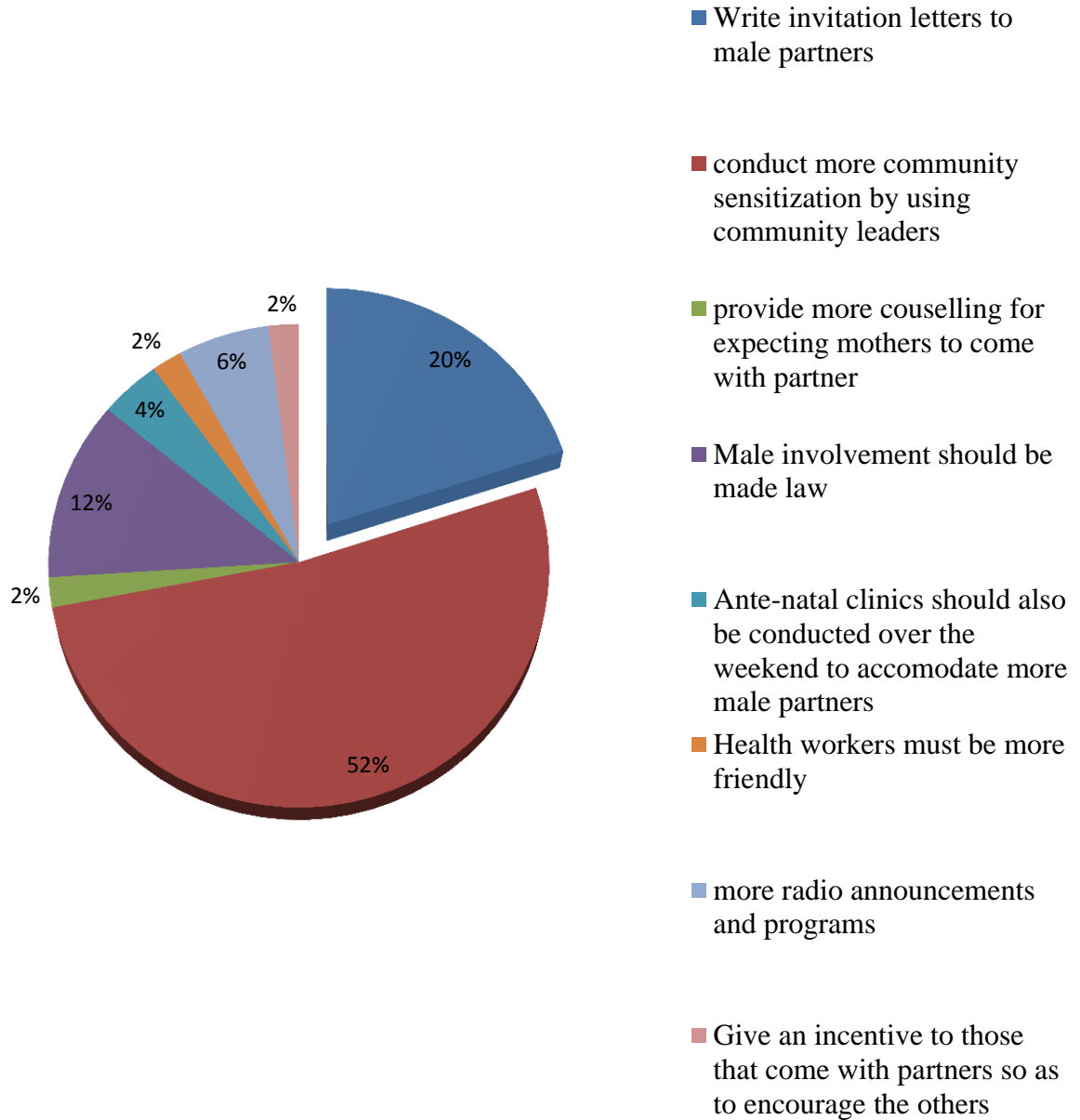


Figure 5.19 Encouraging male involvement in ante natal care (expecting mothers)

The expecting mothers were asked what they thought clinics could do to encourage male involvement in ante natal care. The researcher got a variety of responses but made a summary of these as shown in figure 5.19. Majority of the expecting mothers said conduct more community sensitization using community leaders at 52% followed by 20% who said write invitation letters to male partners. 12% said male involvement should be made law while 6% said more radio announcements and programs should be aired, 4% of the respondents said ante natal clinics should be conducted over the weekend to accommodate more men as they are busy during the weekdays and the remaining said there was need for health workers to be more friendly, giving of incentives to those that come with male partners and provision of counselling about male involvement to women that come with partners, these had 2% each.

What do you think must be done by clinic to encourage male involvement in ante natal care

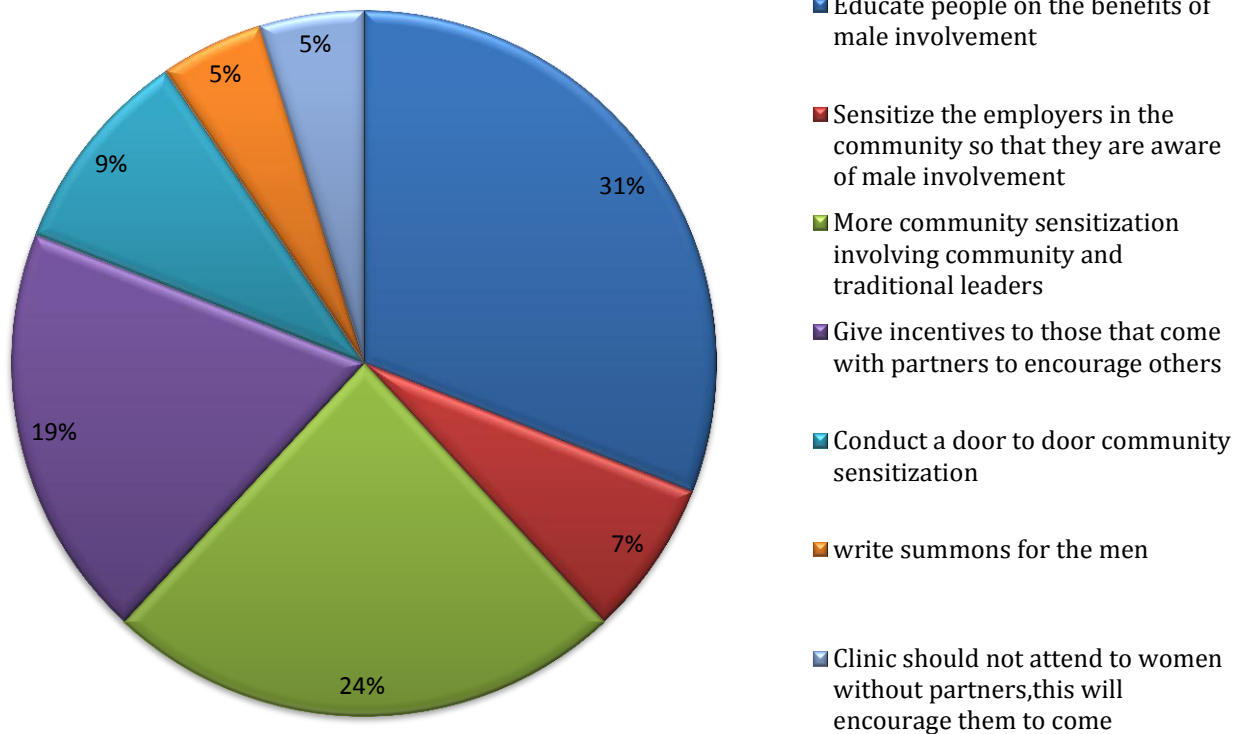


Figure 5.20 Encouraging male involvement in ante natal care (expecting fathers)

The same question about what clinics could do to encourage male involvement in ante natal care was asked to the expecting fathers as shown in figure 5.20. 31% said educate people on the benefits of male involvement followed by 24% who said more community sensitization involving community and traditional leaders and 19% said the health centre should give incentives to those that come with partners to encourage others. The remaining 9%, 7% and 5% said conduct a door to door community sensitization, sensitize the employers in the community so that they are aware of male involvement, write summons for the men and clinic should not attend to women without partners, and this will encourage them to come.

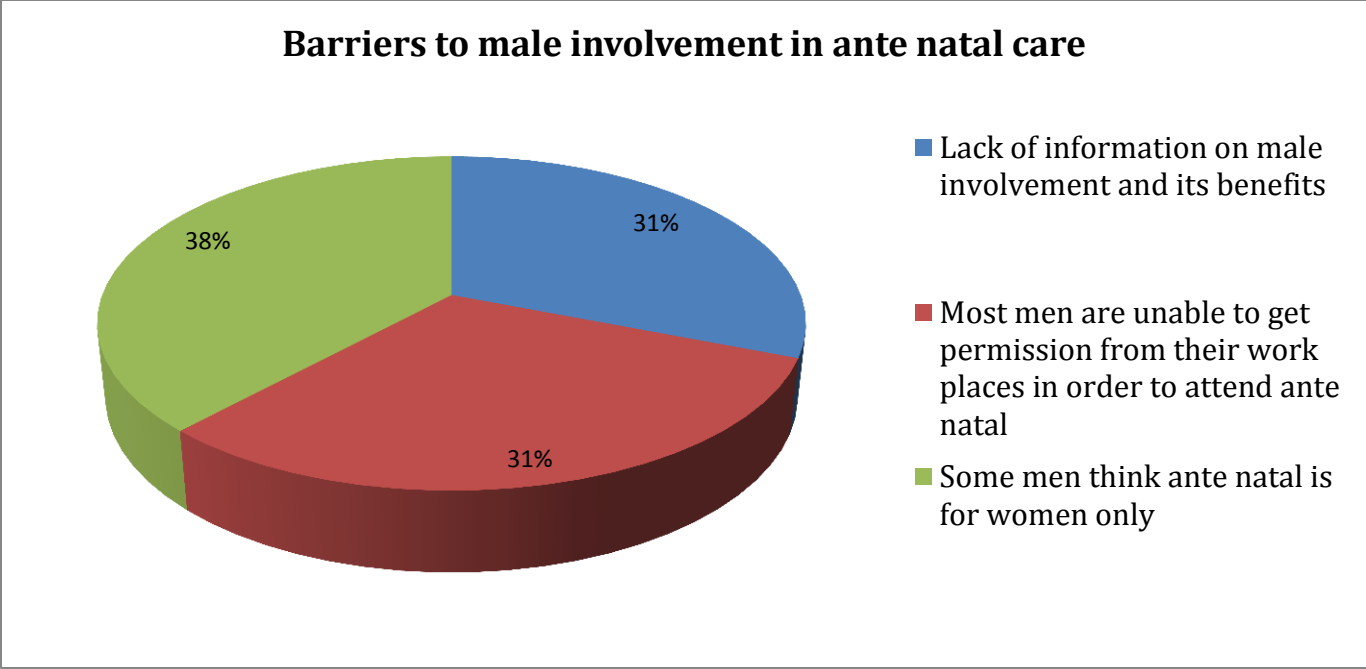


Figure 5.21 Barriers to male involvement in ante natal care

A question was posed to see what the expecting fathers thought was the barrier to male involvement to ante natal care. A number of responses came up and they have been summarized in figure 5.21. 38% of the fathers said the barrier to male involvement in ante natal care was that some men thought ante natal was for women only (hyper-masculinity) while 31% of them each said lack of information on male involvement and its benefits and also most men were unable to get permission from their work places in order to attend ante natal clinics. The other 31% said they were unable to get permission from their work places in order to attend ante natal care sessions.

Socio-cultural factors also played a role in men thinking ante natal clinics were only for women, the action of a husband accompanying the partner for ante natal was somehow still stigmatized. A respondent explained how men that support their partners too much and accompany them for ante natal were said to have charms used to blind them and are under “petticoat government”. The respondent explained this term meant a man who ‘always obeys his wife’ ‘takes orders from his wife’ ‘does what she says’. This respondent further explained this term was coined to mean a husband under the wife’s rule, here the husband pay too much attention to the wife’s needs and

follows her orders instead of attending to his needs. These factors explain the high number of men who thought ante natal was only for women.

The other reason is the job responsibilities of the men and their not being granted permission from their work places. The men's work obligation was also a barrier to male involvement as employment schedules conflicted with the ante natal clinic hours as these clinics were conducted in the morning on a working day. The lack of information on male involvement and its benefits was also a barrier. The low knowledge levels poses as a barrier to men becoming actively involved. The respondents seemed to have a general idea of male involvement though they did not have knowledge particularly in relation to pregnancy danger signs and nutrition.

5.2. Qualitative findings

5.2.1. In-depth interviews

The research conducted 2 in depth interviews with the Maternal and Child Health (MCH) coordinator and Program Coordinator for Mobilising Access to Maternal Health Services in Zambia (MAMaZ) respectively. MAMaZ is a Non-Governmental Organisation working with the Mkushi District Medical office to increase access to maternal health services. During the interviews areas of concern that were covered among others include knowledge about the male involvement in ante natal care, the challenges faced by the fathers in getting involved in ante natal care, the channels of communication and strategies used to encourage male involvement in ante natal care. These interviews were cardinal as they helped the researcher to have an increased understanding of the communication strategies.

From the responses of the interviewees, the researcher came up with the following information, which is according to the areas of concern mentioned earlier.

5.2.2. Interview with District MCH coordinator

The MCH coordinator highlighted the communication strategies used both at the district medical office and in reaching out to the community. The district medical office has communication

strategies within the organisation; these include reports, letters, telephone, meetings, seminars and workshops. The other methods of communication used within the organisation were interpersonal communication (one on one) and memoranda which were stuck on notice boards. He further highlighted that the most prominently used method especially when it came to communicating to the health centres was the telephone, memoranda and seminars.

The coordinator also highlighted the communication strategies used by the district medical office to disseminate information in the community on male involvement. He first began by giving the district picture when it came to ante natal care. For the first ante natal attendance the district was above 85%, some health facilities were even recording above 100% this is because there was a challenge with population as there was a disparity between Central Statistical Office data and the district head count which the district medical office conducts every two years using the Neighbourhood Health Committees (NHCs). The coordinator was quick to mention however that there was a problem with the 3rd and 4th ante natal visit as most women book for ante natal quite late. There was a challenge of late ante natal booking in the district. He mentioned that all in all the district health office through the rural health centres were striving to ensure that they provide focused ante natal care, this care includes testing for HIV and syphilis, provision of drugs like folic acid, ferrous sulphate, mebendazole and fasidar (sulphadoxine and perimethamine) and health education. He explained that in the past the health centres used to focus on the number of visits but now the health centres focus on the quality of services provided during the visits.

On male involvement in ante natal care, the district was at 40% which he mentioned was an improvement in comparison to the past. The health centres that were doing well were those supported by MAMaZ, a Non-Governmental Organisation working with the district medical office. This organisation has been training the community into Safe Motherhood Action Groups (SMAGs). These groups were trained to sensitize the community on safe motherhood and male involvement in ante natal care. The district medical office was using different channels to sensitize the community. The district medical office uses interpersonal communication, group communication, radio programs and adverts, public address system and church announcements. Community workshops and meetings are also used to disseminate information. In these

workshops members of the community are given information and they are accorded an opportunity to ask questions.

Meetings are also held with traditional and community leaders who are opinion leaders in the community. The district health office through the maternal and child health unit conducts the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) meetings within the community on a quarterly basis. The objectives of these meetings were to sensitize the traditional leaders on safe motherhood and use of traditional structures to safe guard the interest of women and their unborn baby. In these meetings, communities had come up with traditional laws to encourage male involvement in ante natal care. One such law is that every man should accompany their spouse to the clinic failure to do so would result in punishment or payment of a fine. These laws were being enforced by the traditional authorities.

The district was running a safe motherhood campaign using the SMAGs; these were trained by the district medical office in conjunction with the cooperating partner MAMaZ. The SMAGs work on a voluntary basis and were only motivated by way of Income Generating Activities (IGA) where they come up with group investments and share the profits. Men are also part of the SMAGs and have been playing an important role when it comes to male involvement in ante natal care as they are in the forefront of encouraging their fellow men to participate in their partner's pregnancy. As part of the campaign the district community medical office has also introduced incentives to encourage male participation in ante natal care. The first incentive was that of ensuring that pregnant women who turn up with their partners were attended to first. Having realized that men had busy schedules and one of the reasons they could be shunning ante natal sessions was because of the long time it took for one to be attended to, the medical office introduced a fast track service to women who were accompanied by their partner. It had been observed that this has been encouraging most men to turn up.

Another incentive was the giving of two insecticide treated nets to those that were accompanied by their partners instead of one as per requirement. The coordinator was however quick to mention that this incentive was not available to all rural health centres in the district as it was very costly to sustain. In centres where it was being implemented the level of male involvement had increased.

The SMAGs were being used to sensitize the community on different messages like the importance of good nutrition, pregnancy danger signs, male involvement, Prevention of Mother to Child Transmission and the importance of delivering at the health centre. Drama, songs and hand gestures were used for easy remembrance of the messages. Figures 5.22 and 5.23 show pictures of the SMAGs using body gestures to communicate the message of the pregnancy danger signs:



Figure 5.22. Body language tools used by the SMAGs to communicate pregnancy danger signs

Extract from the Mkushi district MAMaZ EOP publication



Figure 5.23. Body language tools used by the SMAGs to communicate pregnancy danger signs

Extract from the Mkushi district MAMaZ EOP publication

The coordinator emphasized that the use of body gestures to relay ante natal messages by the SMAGs has been very successful and has helped in reducing maternal mortality. Since many SMAGs had poor literacy, the district medical office through MAMaZ saw it important to identify training methodologies that did not rely on the use of written manuals. The use of communication body tools enabled volunteers to quickly acquire and retain knowledge, and to rapidly develop the capacity to train others effectively. Key messages were presented by a gesture or pose. Participants learnt to ‘do’ the action and to ‘say’ the message. Songs, sometimes combined with mime, were also used to reinforce key issues. These training methodologies had proved effective and continue to be used throughout the district.

5.2.3. In-depth Interview with MAMaZ coordinator

MAMaZ was established in Mkushi in 2011 and the aim was to support communities to mobilise around a Maternal Newborn Health (MNH) agenda by increasing knowledge, capacity and confidence to address some of the barriers to improved health outcomes for women and newborns. As the program was beginning there was a demand side assessment that was carried out in the community. This assessment revealed that men were not involved in ante natal and this had a negative impact on institutional utilization. Men when knowledgeable can play an important role especially in case of a maternal emergency they can be quick to act as they are taught on the safe pregnancy and delivery plan.

According to the coordinator, the MAMaZ approach was based on a volunteer model and as part of the national safe motherhood policy response, the district had already established Safe Motherhood Action Groups (SMAGs) around several of its Basic Emergency Obstetric Care facilities (BEmOCs). The organisation worked through the existing SMAG structure that was revisited and adapted, based on a system of lead community health volunteers (Lead Mama SMAGs) who were coordinating and supported a larger group of regular volunteers (Mama SMAGs). Mama SMAGs had been trained to facilitate the community mobilisation process and to support the establishment of various community systems.

The coordinator further explained that many volunteers were not able to read and write so the organisation had identified training methodologies that did not require the use of written manuals. The use of communication body tools had enabled volunteers to quickly acquire and retain knowledge, and to rapidly develop the capacity to train others effectively. Key messages were presented by a gesture or pose. Participants learnt to ‘do’ the action and to ‘say’ the message. Songs, sometimes combined with mime, were also used to reinforce key issues. The organisation had a comprehensive approach which included the following:

- Community Mobilisation
- Mentoring and Support
- Community Monitoring
- Facility-based Emergency Transport

- Community Systems Improved Access to Maternal and Newborn Care

The organisation had been using the above as effective ways to reduce barriers to institutional utilization of maternal health services. Male involvement had been incorporated in this comprehensive approach and the organisation had adopted it as it was a government policy. The implementation of the program in the initial stages faced some resistance even from the community leaders who thought that it was part of the gender movement and was designed to bring problems in families.

The coordinator sighted the problem of hyper masculinity where men thought they had dominion over women. He explained that hyper masculinity was a gender-based ideology of exaggerated beliefs about what it was to be a man. Having this type of attitudes in the community proved to be a challenge especially at the beginning of the sensitization program but this was slowly changing. The organisation had been working tirelessly with the community leaders as focal persons.

Meetings were held in the communities with the traditional leaders and their subjects. These were called rapid awareness comprehensive meetings and they had been instrumental in coming up with traditional by-laws to encourage male involvement in ante natal care. For instance, a law had been passed where if a male partner did not accompany their spouse to ante natal they were punished by way of digging farrow in the community. The traditional leaders had been made focal persons in order to encourage sustainability of the programs in the communities. They had played a vital role in the male involvement in ante natal care program, the recognition of the MAMAZ sensitization program had not only been critical in motivating the volunteer SMAGs but were taking a very active role of calling for discussion groups and encouraging male community members to participate.

The organisation was also using the SMAGs to sensitize the community. This was being done in conjunction with the district community medical office, and the channels being used were sketches, demonstrations through the body language tools, songs, group discussions and message on T-shirts usually worn by the SMAGs. These SMAGs were motivated through small incentives like T-shirts, food and money which the organisation did not call allowance but instead called it

a little appreciation for the voluntary work the SMAGs were doing. The organisation so far had been able to achieve positive progress in terms of increased institutional utilization through the community engagement approach.

The in-depth interviews revealed that indeed both the government and the non- governmental organisations communicate to the public on the importance of male involvement in ante natal care and the efforts were bearing fruit. This cooperation was good as it avoided duplication of efforts and it also allowed for sharing of information and resources. However, the researcher noted that there had been no systematic evaluation of these communication strategies. It was encouraging to note that MAMAZ had included the promotion of male involvement in ante natal care in its comprehensive approach in the maternal and newborn agenda.

5.3. Focus Group Discussion

During the focus group discussions areas of concern were covered which included among others; knowledge about the male involvement in ante natal care, the challenges faced by the fathers in getting involved, the channels of communication and strategies used to encourage male involvement in ante natal care.

5.3.1. Level of knowledge on male involvement

From the focus group discussions, it was very clear that the health workers seen and spoken to knew what male involvement in ante natal care was and how best it can be effective. The knowledge about it being a policy was very clear as evidenced in the discussion (especially the health providers working in the maternal and child health department) who expressed knowledge. The health staff duty had been to encourage the males that it was government policy that every pregnant woman was accompanied for ante natal care by their spouse.

Among the benefits of male involvement in ante natal care as outlined through the focus group discussion; that it helped male partners to be responsible (knowing what was happening and ensuring nothing goes wrong) for the pregnancy, men also learnt child spacing and its importance, it also helped the couple to remember instructions given during ante natal and where

treatment was prescribed it made the couples easily adhere to it. Once the male partners were getting involved in ante natal care, they got to know the pregnancy danger signs and complications before they advanced.

Expecting mothers found their spouse (who got involved in ante natal care) helping with house chaos during the pregnancy making it easy for the expecting mothers to go through the pregnancy. Male involvement in ante natal care also helped the couple prepare adequately together for the baby before it was born. In some areas visited the benefits were very tangible like expecting mothers who came with their spouse were given chitenge materials (wrappers), or were possible they received sponsorship for their Income Generating Activities (IGA) and at times mosquito nets were given. For the prevention of mother to child transmission (PMTCT) it became easier for the couple to get counselling on how to ensure they both stayed safe together with the baby.

5.3.2. Barriers to male involvement in ante natal care

The program of male involvement in Ante Natal Care (ANC) also had challenges which were mainly health service related and socio-cultural challenges. Some of the challenges outlined during the focus group discussions include; negative cultural perceptions, long ante natal waiting time, infrastructure (venue and space constraints), low knowledge levels, men's job responsibilities, fear of being tested for HIV, transport constraints, female attitudes and gender based violence.

Some men felt that they (traditionally) could not be involved in women issues (which included ante natal). It was perceived that when a man began accompanying the wife for ante natal care then such a one had lost control over his home or the woman had given him some sort of charm (love potion) to control him. Men who accompanied their wives to ANC services were still perceived as being dominated by their wives though it was now changing. Frequently men perceive that ANCs services were designed and reserved for women, thus were embarrassed to find themselves in such "female" places.

Certain women too, did not like attending the ANC services with their male partner. These women feared that discovery of a positive HIV test result may lead to abandonment, rejection or

being perceived by their husband as being responsible for bringing HIV into the couples' relationship. This was mostly common with women experiencing gender based violence. The informants also cited gender-based violence as being another cause of low male involvement. Victims of gender-based violence could be afraid to ask their partner to be tested for HIV. Reinforcement of women's' power for negotiation could be a major asset in the promotion of male involvement in ante natal care.

The long waiting time was also a barrier to male involvement. At times when the men accompanied the expecting mothers they wanted to quickly be attended to and not spend the whole day or the whole morning at the centre (which most of the times was not possible as the process takes a bit of time explaining to the expecting mothers and their spouse if they have come with them). Couples waited for a long time before receiving ANC services because of long administrative procedures which resulted in poor client turn out. Mkushi being a farming community had a lot of men in the paid workforce; these were often not in a position to spend virtually the entire day participating in ANC services.

Infrastructure also acted as a barrier to male involvement as the health centre didnot have enclosed shelters were meetings for ante natal with the couples could be done and this made most of the men feel uncomfortable being seen by others that they had accompanied their wives. The lack of space to accommodate male partners in ANC clinics was also reported to adversely impact male involvement. Some health centres were often unable to concurrently accommodate and adequately attend to pregnant women and their partners because of a lack of space. On this issues in some areas, most older men felt uncomfortable being in the same place with younger men when discussing ante natal related issues while at the same time younger men who have older women as their spouse felt uncomfortable being seen by others. At times parents in-law were found to be in the same place with their in-laws which made things not easy for each party based on tradition (traditionally certain issues could not be spoken in front of the in-laws especially ante natal care related issues).

Another challenge that was faced by men involving themselves in ante natal care was lack of knowledge of the importance of males accompanying their spouse for ante natal and the benefits. The informants explained that most men still did not understand the benefits of male

involvement, the health workers suggested that this could be overcome by conducting a massive sensitization campaign.

The fear of being tested together and the spouse knowing the status also made it not easy for most men to adhere to the program. Because most men knew that ante natal care dealt mainly with testing for HIV status ended up avoiding ante natal for fear of knowing their HIV status. Fear of receiving an HIV positive result and confidentiality concerns prevented some men from coming for VCT. In many studies men were mentioned being concerned about HIV-associated stigma and disclosure. Men could be afraid of HIV status disclosure in a health system facility, in the context of weak health system. An interesting comment that came out as a challenge for male involvement in ante natal care was that most men refused just because they were rigid. This is so because of the upbringing of most men, they were told that a boy or man could not be involved with girls/women issues. The other challenge was that most young men drink alcohol too much such that they were not interested in ante natal care. At times their spouse would be giving birth while they (the men) were drinking or if there was a complication they would not know because they would be very drunk.

Distance from home to the health centre was also among the challenges faced. The male counterpart would normally find it hard to return to their work if they escorted their wives/spouse for ante natal care. Access to the health centre for those living in far flung areas was a challenge especially with the high transport costs.

5.3.3. Channels used to communicate male involvement in ante natal care

However despite the challenges faced, the health providers spoken to said they had various channels and strategies in place that could help encourage the male involvement in ante natal care. Most health centres had come up with a policy that women who came with their spouses were attended to first no matter what time they came and in doing so other women without their spouse had been encouraged to come with their partners on the next visit. One on one method (interpersonal communication) which was done when expecting mothers came for ante natal or to the public in general during their visits to the health centre in a group set up at Out Patient

Department, was a participatory method as it was interactive. During the group health education session the message of male involvement in ante natal care was disseminated

The other channel of communication was through radio presentations where health workers from the centre conducted programs on radio on male involvement. The health workers even took a road trip into the community where door to door campaigns were conducted and drama performances through the use of sketches and songs. The health centre also involved church leaders in the campaign as these had a great influence in the community

In some areas the involvement of traditional leaders and influential leaders in the community like headmen, church leaders and councilors was used which from the respondents' perspective had yielded good results. This was done by asking the traditional leaders to invite people for the meeting and then allow the health personnel to sensitize them on the importance of male involvement in ante natal care. The health centre was planning to hold a sensitization workshop for the headmen in the community. These were then going to help the mass sensitization in the community.

The message that was generally communicated through the above channels and strategies was all about male involvement in ante natal care, its importance (benefits). Among the benefits communicated through the channels and strategies included the involvement of male in ante natal care enabled the couple to know any signs of problems or dangers to the mother or the unborn child. Also the male would understand much more about how to treat the wife during her pregnancy by helping with house chores from time to time. The other message was that it was government's policy that all expecting mothers be accompanied by their spouses for ante natal care.

An observation was made that sensitization would be much easier if the health centre provided the means of transport in form of bicycles to enable the community health workers reach the target audience in far places and conduct sensitization on male involvement in ante natal care. This also could enable workers understand the challenges faced by their clients and later appreciate those who made efforts to reach the health centres on time. The research also observed that such moments of allowing the staff and the people interact to exchange views regarding the running of sensitization programs on male involvement in ante natal care needed to

be done more frequent and out of such encounters any challenges identified could be addressed by parties responsible.

In conclusion, the informants hoped that the findings of this research could enable the policy makers also improve on the policy governing the running of health centres and at the same time help the health personnel do their best in delivering quality health care services to the expecting mothers and educate the men on how best to treat and care for their partners.

CHAPTER SIX

6. DISCUSSION OF FINDINGS

6.1. Introduction

This chapter presents a discussion of the findings. The main research objective is to evaluate the communication strategies being used by the Mkushi District Medical Office to promote male involvement in ante natal care. The discussion of the findings was arranged according to the objectives.

6.2. To establish the types of communication networks existing within the community medical office as an organisation concerning male involvement in ante natal care

The research revealed that communication within the district community medical office was done using a number of methods; these included reports, letters, e-mails, phone calls, meetings, seminars and workshops. The other methods of communication used within the organisation were interpersonal communication (one on one) and memoranda placed on the notice boards. The most prominently used methods, especially when it came to communicating to the health centres were the phone, memoranda and seminars. As an organisation tasked to coordinate and spearhead activities on behalf of the health centres, the aspect of communication was important for efficient and effective running of the health facilities.

The district medical office maintains constant communication with the District hospital, health centres, partners and other stakeholders in order to ensure there is flow of information within the system. The district medical office as a focal organisation had also invested in a Local Area Network (LAN) and all computers within the organisation were connected to this network. This had established internet and e-mail facilities in the organisation and had enabled the organisation to interact more easily with their partner and donors. Communication networks were extremely useful in an organisation as they fostered transparency in the operations of projects/work, through communication at all levels and all stakeholders. Communication within and outside the organisation helped to convince funders, clients, beneficiaries and staff that the

organisation provided quality health services (Chikati,2009,p.40). A well organised and focused communication network makes the task of health communication and promotion much easier in a sense that it showed what the organisation was doing, why and where it intended to lead.

6.3. To examine the communication strategies used by the district medical office in promoting male involvement in ante natal care

The district medical office had recognised that there was need to engage a multimedia approach in promoting male involvement in ante natal care. The following were the strategies the community medical office was using to promote male involvement in ante natal care:

6.3.1. Radio

The district medical office had been using the community radio station to disseminate information on male involvement in ante natal care. This was done through radio advertisements and programs. The district was running maternal health programs funded by Glaxo Smith Kline (GSK). These were phone-in programs that were running for 45minutes and the listeners were given an opportunity to ask questions. There were also advertisements that were running during prime time, for instance, just before the main news. From the research findings, one can see that radio was indeed a prominent source of information for the ante natal clients. When the clients were asked how they knew about the ante natal services offered at the health centre, 38% said they got this information from the radio and most of them indicated that they specifically got it from Mkushi community radio. A total of 38% mentioned friends as their source, while 18% said relatives, while 4% and 2% mentioned health education sessions and public address system respectively. The community radio had become a platform for participatory communication as it mostly served the interests of the community.

6.3.2. Health education sessions (Group Communication)

This method of communication was one of the most common. It was observed during the research that most of the times the health staff spoke directly to the audience on issues of health. During this interaction an opportunity was presented to the couples to ask questions to have their doubts cleared. One aspect that came out during the structured interviews with the mothers was

that there was usually a limited time for communication between the expecting mothers and the health staff. Such results suggested that there was limited time between the couples and health provider to be adequately educated and informed about their health. The health centre staff explained that due to poor staffing levels at the health centre they had no choice but to attend to the ante natal mothers as fast as they could to ensure that everyone was attended to. They further explained that this was not good for the expecting mothers as there was need for them to be given all the information that was necessary. They explained that sadly this situation had led to mothers resorting to the Traditional Birth Attendants (TBAs) to get more information and have sometimes been misinformed. This sometimes warrants the TBAs to work beyond their competence and limitation. The need for accurate information to be given to the expecting mothers cannot be overemphasized as this would greatly help the mothers. In addition, it would help reduce delays in seeking health care and this would ultimately reduce maternal mortality.

6.3.3. Community meetings

Community meetings were conducted during community outreach programs by the health centre and talks were conducted during these meetings. Community meetings were organised through the Neighbourhood Health Committees (NHCs). These were called Campaign on Accelerated Reduction of Maternal Mortality (CARMMA) meetings and were specifically held to address maternal health issues. The health centre targeted community members who were opinion leaders such as chiefs, headmen, councilors, church leaders and other community leaders that were able to influence the views of the community. The community medical office took advantage of the already existing community structures to reach out to the people though they also had a substantial presence through the NHCs.

The objectives of these meetings were to sensitize the traditional leaders on safe motherhood and use of traditional structures to safe guard the interest of women and their unborn babies. These meetings have helped communities to come up with traditional laws to encourage male involvement in ante natal care. One such law is that “every man should accompany their partner to the clinic, failure to do so will result in punishment or payment of a fine.” These laws were being enforced by the traditional authorities.

A total 36 out of the 92 respondents thought community meetings and the involvement of community and traditional leaders was an effective way of promoting male involvement in ante natal care. Involving community leaders who were also opinion leaders in these communities was cardinal to the dissemination of information in the community. The dissemination happened through the diffusion process, male involvement in ante natal care an innovation in this case. All the way through the diffusion process there was evidence that not all individuals exercise an equal amount of influence over other individuals. In this sense there were Opinion Leaders; leaders who are influential in spreading either positive or negative information about an innovation. Rogers relies on the ideas of Katz & Lazarsfeld and the two-step flow theory in developing his ideas on the influence of Opinion Leaders in the diffusion process (Katz, Elihu & Lazarsfeld, Paul 1955 p.19). In addition, opinion leaders have a set of characteristics that set them apart from their followers and other individuals. Opinion Leaders typically have greater exposure to the mass media, more cosmopolitan, greater contact with change agents, more social experience and exposure, higher socioeconomic status, and are more innovative. It is, therefore, paramount to use opinion leaders in the promotion of male involvement in ante natal care.

6.3.4. Community drama

In trying to promote male involvement in ante natal care the district community medical office had been using the Safe Motherhood Action Groups (SMAGs) in theatrical performances to relay the message. Here community mobilisation was used to ensure participation of the community members. The SMAGs were community members that had been trained in sensitization of the community in safe motherhood. Mobilising the community in trying to promote their health was important as they needed to be part and parcel of the process of change. The aspect of community mobilisation was important especially in the introduction and sustenance of a community concept that would benefit the community in the long run. Community mobilisation is a process of engaging communities to identify community priorities, resources, needs and solutions in such a way as to promote representative participation, good governance, accountability and peaceful change. Community participation is about meeting the interests of the larger part of the community, (Unicef consultative report 2004, p.2). This was because when every member of a community had a chance, directly or through representation to

participate in the design, implementation and monitoring of community level initiatives, there was a higher likelihood that the program reflected their real needs and interests (Unicef consultative report 2004, p.2).

6.3.5. Public Address System

The district community medical office also used the public address system to communicate to the community. This was usually done during the child health week and the safe motherhood week. This was not done on a regular basis but it complemented the other communication methods that were used regularly.

6.4. To determine the messages the District Community Medical Office communicated to the community.

The significant message conveyed on male involvement was the need for couples to be aware of the danger signs of pregnancy, to know their HIV status and for men to play a supportive role throughout their partner's pregnancy. From the focus group discussion findings, the health workers indicated that the key messages disseminated were on the benefits of male involvement in ante natal care to both the clients and the health providers. For the posters, brochures and other print materials, the messages were coined at the Ministry of Community development, mother and child health headquarters in Lusaka. This also applied to the message packaged on the television program "Your health matters" as it was also done at the Ministry of Health headquarters.

6.4.1. Target Audience

For messages to be disseminated effectively there was need for audience segmentation. Every message when packaged needed to target a certain audience. A target audience is group of people that the communication activities are aimed at. It can be people of a certain age group, profession, gender, marital status, educational background and geographical area, (NWASCO communication strategy 2008-2009 report, p.7). For the Mkushi District Community Office their target audience was people in the reproductive age. From the information gathered, the researcher noticed that the target audiences that the district community medical office reached out to was not clearly segmented hence messages were not well packaged. The segmentation that

follows is what the researcher classified after observation and analysis of the data collected for better understanding of the roles each played. It was important to segment audience so that the District Community Medical Office knows which message to disseminate and to which audience. This makes messages disseminated to achieve the intended purpose.

Primary audience – is a group of people that the communication activities are aimed at and are usually the primary point of contact. These are the people who the message needs to be communicated to and are likely to directly benefit from the information, (NWASCO communication strategy 2008-2009 report, p.7). The primary group is very difficult to reach if appropriate communication strategies that suit are not put in place. In the promotion of male involvement in ante natal care the primary audience was everyone of reproductive age and was likely to have children.

Secondary audience – this is a group of people who have some knowledge of the messages to be communicated but will however benefit from hearing the message, (NWASCO communication strategy 2008-2009 report, p.7). Examples of such groups are various stakeholders such as civil society, NGOs and churches. These groups are usually change agents and can influence the primary audience.

Special audience – these include government and the media (NWASCO communication strategy 2008-2009 report, p.7). This group needs the information so that they can propound sound implementation of the policies.

6.5. To find out the perceived barriers faced by men in trying to get involved in ante natal care.

The usage of the ante natal care services was hampered by different barriers which came to light when the respondents were asked on the barriers to male involvement in ante natal care. A total of 38% of the fathers said their barrier to male involvement in ante natal care was that some men thought ante natal was for women only (hyper-masculinity) while 31% of them each said lack of information on male involvement and its benefits and also most men were unable to get permission from their work places in order to attend ante natal clinics. The other 38% said they

were unable to get permission from their work places in order to attend ante natal care sessions. The barriers highlighted were explained as follows:

Societal stigma - the research found out that societal stigma in this community was a barrier to male involvement in ante natal care. Most men thought ante natal clinics were only for women, the action of a husband accompanying the partner for ante natal was somehow still stigmatized. A respondent explained how men that support their partners too much and accompany them for ante natal were said to have charms used to blindfold them and hence were under “petticoat government”. The respondent explained that “petticoat government” meant a man who ‘always obeyed his wife’ ‘took orders from his wife’ ‘did what she said’. This respondent further explained this term was coined to mean a husband under the wife’s rule, here the husband paid too much attention to the wife’s needs and followed her orders instead of attending to his needs. This cultural factor explains the high number of men who thought ante natal was only for women.

Job responsibilities - the other barrier to usage was the job responsibilities of the men and their not being granted permission from their work places. The men’s work obligation was also a barrier to male involvement as employment schedules conflicted with the ante natal clinic hours as these clinics were conducted in the morning during weekdays.

Low knowledge levels - the lack of information on male involvement and its benefits was also a barrier. The low knowledge levels posed as a barrier to men becoming actively involved. The respondents seemed to have a general idea of male involvement though they did not have knowledge particularly in relation to pregnancy danger signs and nutrition.

Inadequate transport money – the limited transport money for the couple to attend ante natal was also a contributing factor to the low levels of male involvement in ante natal care. This was because of the harsh economic conditions prevailing in Mkushi. Some men were only able to afford transport for their partner as they stayed back home to work and make ends meet. The majority of the men were farm labourers.

Lack of male friendly ante natal care services - out of the 42 male respondents that were interviewed 14 said the ante natal care services were not friendly. Although the majority said the services were male friendly, the researcher saw the views of the smaller fraction (14 who said no) as a cause for concern as this also posed as a barrier to male involvement in ante natal care. The 14 respondents gave different reasons for saying ante natal clinics were not male friendly.

Some men said health education was conducted outside the health centre; however the researcher observed that there were infrastructural constraints faced by the Mkushi district medical office in most of its health centres as the population had increased over the years. Most infrastructural needs to be upgraded especially the Mother and Child Health (MCH) department. There was need for an enclosed area not only for privacy and confidentiality during counselling sessions but also for physical cover during bad weather. Insufficient space and lack of privacy accounted for one of the reasons those men in Mkushi thought ante natal services did not still accommodate them.

At the time of the research the ante natal clinics only had female health providers except one community male volunteer who helped in conducting health education at times. Some men indicated they were not free to express themselves on sensitive issues and suggested that the health centre also assigned male health providers. Some men also indicated that they were not involved in a lot of activities except for HIV testing; this complaint was coupled with the long waiting time they experienced at the health centre. They explained that after the health education and HIV testing, men were left with nothing to do except to watch their partners being attended to. The long waiting time was said to be due to low staffing levels at the ante natal clinic, this also complicated the situation as it discouraged men from coming for ante natal clinic.

6.6. To ascertain what type of communication existed between couples and health providers concerning male involvement in ante natal care

6.6.1 Communication between couples

Before ascertaining the type of communication that existed between couples and health providers, the researcher wanted to first determine if there was effective communication within the couples as this could have a bearing on how they communicated with health providers.

When the respondents were asked if they discussed ante natal issues with their partners, 81% of the respondents said they discussed ante natal issues while 19% said they had not discussed ante natal issues with their partners. Investigating to see if couples discussed ante natal issues was of great importance to this research because decision making and care seeking as a process facilitated good family reproductive health. Having seen that the majority of the respondents communicated with their partners, this entailed that partnership, care and support of women had been enhanced through sensitization on their reproductive roles and this had further facilitated couple reproductive communication. A respondent narrated how her partner would sometimes remind her to take her iron tablets and also show interest to know her experience at the health centre despite him not consistently accompanying her for ante natal.

This research further reveals that couple communication is sometimes restricted by culture and individual disposition, this seemingly rendered men's limited knowledge of women's reproductive needs. Of the 19% who had not discussed ante natal issues with their partners some men said they felt ashamed to talk to their partners about the reproductive issues and this was because of how they were culturally brought up. The discomfort experienced in couple communication was not limited to men. The women also expressed sentiments of feeling shy to talk about reproductive issues with their partners. Some women found it difficult to discuss reproductive issues with their partners and this had resulted in difficulties for women seeking care early enough. Couple communication was a crucial step in increasing male involvement in ante natal care. It had been reported by many health providers that couples who discussed ante natal issues were likely to attend ante natal clinics together.

6.6.2. Communication between couples and health providers

The majority of respondents said they were able to communicate freely with the health providers. Out of the 92 respondents interviewed 80 answered in the affirmative and 12 indicated that they were not freely able to communicate. Of those that said they did not freely communicate with the nursing staff, 55% said they felt shy while 27% said there was limited time for the ante natal sessions and 9% each said health providers were not friendly and health education sessions were done in a group so that it was not easy to ask sensitive questions in order to get adequate information. For those that felt shy, they explained that reproductive matters were not easy to talk about and that's why they chose to be quiet. The respondents that indicated that there was limited time for them to communicate freely explained that there were too many activities packed in one ante natal session. So this meant that there was limited time and opportunity for them to ask questions during antenatal visits and have their doubts cleared. The respondents said they spent approximately 3 minutes or less privately with the health provider. Such results suggest that there was limited time for expecting mothers to be educated and informed about their health needs and have the opportunity to ask questions and have their doubts cleared. This led to limited information for most women and eventually led women to not recognizing the need for her partner to get involved in ante natal care.

Other respondents indicated that the health providers at the health facilities were not friendly, in that they lacked interpersonal skills such as empathy and sensitivity. The last category said health education was conducted in the group so it was not easy to ask questions, they explained that in a group confidentiality did not exist.

6.7. Challenges facing Mkushi district community medical office in implementing male involvement in ante natal care.

The district community medical office had made strides in the promotion of male involvement in ante natal care; however this had not been free of challenges. The district medical office was facing a number of challenges, among them:

6.7.1 Inadequate human resource

There was inadequate human resource in the district especially in the maternal and child health department. This had led to overcrowding and the long waiting time for the couples to be attended to. This stood as a barrier to male involvement in ante natal care as most men were only given a short time off work to attend ante natal clinics. The inadequate staffing levels have also led to the staff being overworked and stressed especially with the growing population. In this context, the quality of service was compromised as there were only a limited number of staffs attending to ante natal clients. The tedious process of documentation during the ante natal also put the staff under a lot of pressure and increased the workload.

6.7.2. Financial constraints

Limited funding to the health centres had also negatively impacted the implementation of male involvement in ante natal care program. Due to inadequate funding the health centres had not been able to carry out sensitization programs on a monthly basis due to lack of fuel and allowances to pay the staff as they carried out these duties.

6.7.3. Limited infrastructure

The limited infrastructure had resulted in lack of space to accommodate both women and men when they came for ante natal clinics. This had adversely impacted male involvement in ante natal care. Some health centres due to lack of space were finding it difficult to concurrently accommodate pregnant women and their partners due to lack of space

6.7.4 Lack of translated print materials

The district community medical office did not have translated print materials to use in their sensitization of male involvement in ante natal care. The native languages in Mkushi are Lala and Swaka. They did not have a single poster, brochure or flyers in these languages for people to read and be informed. Printed materials had an advantage in that the targeted audience was able to access information without having to initiate action and they also had a long staying power.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

7.1. Introduction

This chapter presents the conclusion and recommendations that are derived from the findings of this study.

7.2. Conclusion

Male involvement in ante natal care is dynamic as it depends on a myriad of factors including socio-economic and cultural issues. Therefore the process of communicating and promoting has to take multimedia approach to ensure success. This is the communication which is concerned with developing the awareness, knowledge, motivation and skills of people using a whole range of approaches. Communication that offers an opportunity for feedback affords greater potential for communicating complex messages and influencing behaviour.

This research evaluated communication strategies used by the Mkushi district community medical office to promote male involvement in ante natal care. The study concluded that the community medical office used letters, emails, reports, phone, meetings, seminars and workshops. The regular sources of information for the community on male involvement in ante natal was the Mkushi community radio to disseminate information, however this was dependent on how well the district medical office was funded as these radio programs and adverts were paid for. Apart from the radio, the community medical office used health education to reach out to the community when they came to the health centre and when there were outreach programs in the community. The public address system was used though not regularly and the other communication methods were the community meetings, drama, posters and brochures.

The study also deduced that the major barriers to male involvement in ante natal care were societal stigma, job responsibilities, the low knowledge levels and lack of male friendly ante natal services. Another understated barrier was that those men who impregnated their partners out of wedlock were shy and embarrassed to come for ante natal sessions. Controlling such

factors required ardent action oriented approaches that could help in attracting men to come onboard.

The district medical office was facing challenges that needed to be addressed in order to implement male involvement in ante natal care. There was inadequate human resource which led to long waiting time for the ante natal clients. This was also compounded by the burdensome administrative procedures during the ante natal clinic. The limited funding had led to the district community medical office not being able to adequately carry out their sensitisation programs. The district community medical office also faced a challenge of limited infrastructure especially in the MCH department. They also did not have translated printed materials in local languages to help in the sensitisation on male involvement in ante natal care.

7.3. Recommendations

Understanding ante natal care issues and developing effective interventions that address contemporary maternal health issues requires planning, implementation and evaluation of maternal health programming and activities. Therefore, this study apart from fulfilling an academic requirement bore the following recommendations that beckon for both public and private attention to promote male involvement in ante natal care.

- Sensitisation of community members especially elderly women, mothers and mothers' in-laws on men's involvement in ante natal care and child birth through traditional structures such as village development committees.
- Considerations should also be made to include men's involvement in midwifery training programs to better prepare midwives on their critical role in getting men more involved in reproductive health care. Refresher courses should be conducted for midwives and nurses in the entire district.
- Using an appointment system and/or letter of invitation by the health provider and should consider broadening services to weekends. There is need to reorganize ante natal services to be friendly and flexible to both men and women who work during the week.

- Opinion leaders play an important role in influencing others to adopt an innovation. The research noted that the district community medical office was using some opinion leaders like chiefs; there was also need to involve the political structures in the district to enforce male involvement for better behavioural outcomes. This entails the involvement of the members of parliament, the district commissioner and the ward councilors, these command authority in the community and their input would go a very long way.

- The District Community Medical Office should find a way to motivate the Safe Motherhood Action Group (SMAGs) in terms of financial or material appreciation. The SMAGs go out to sensitize the community voluntarily and were not paid anything; these community workers sacrifice their precious time just to educate people on the importance of male involvement in ante natal care. For them to work effectively, they should be motivated financially and materially so that they should not get frustrated.

- To reduce the negative impact of cultural beliefs and opinions among men on male involvement in ante natal care, the District Community Medical Office should come up with context specific and cultural sensitive messages to be disseminated through a multimedia approach throughout the district.

- Ante natal clinics should be made more male friendlier and health providers should ensure they are conducted in a good environment for instance in more private and spacious rooms.

- A deliberate program and effort should be made on the side of the health centres to be sending reminder messages to the couples through Short Message Service (SMS) about two days before ante natal.

- The health centres should also send reminder messages through the church and schools.

7.4. Further research

- A study should be done on the readiness of health institutions in Zambia in as far as male involvement in ante natal care is concerned. This study should focus more on the readiness of health workers and in terms of the infrastructure available.
- A study should also be conducted to determine whether male involvement in ante natal care has contributed to the reduction in maternal mortality in Zambia.

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APPENDICES

APPENDIX 1:

Questionnaire for Expecting Mothers

Section A. Personal Information

1. Age

- (a) 12-19 ()
- (b) 20-35 ()
- (c) 36-45 ()
- (d) 46 and above ()

2. Marital status

- (a) Single ()
- (b) Married ()
- (c) Widowed ()
- (d) Divorced ()
- (e) Separated ()

3. Educational level

- (1) No formal education ()
- (2) Grades 1-7 ()
- (3) Grades 8-9 ()
- (4) Grades 10- 12 ()
- (5) Colleges and university ()

4. Can you read and write

(a) Yes ()

(b) No ()

Section B

5. Have you ever heard of an ante natal message on media?

(a) yes () (b) no ()

6. If yes which media??

(a) Radio

(b) Television

(c) Newspaper

(d) Other, specify.....

7. How often do you listen to ante natal programs on the above mentioned media?

(a) Very often (b) often (c) sometimes (d) rarely

10 What is your regular source of information on your partner's involvement in ante natal care?

(a) Radio

(b) Television

(c) Newspaper

(d) Health providers

(e) Other, specify

Section C

11. What number is your current pregnancy

12. How did you find out you were pregnant

- (a) Missed period ()
- (b) fell sick ()
- (c) when I went to the clinic or hospital ()

- (d) Friends and relatives ()
- (e) Others, specify

13. How did you know about ante natal services offered at this clinic?

- (a) Radio () (b) Television () (c) Newspaper () (d) friend () (e) Others, specify.....

14. Why did you register for antenatal checkups?

- (a) To ensure a healthy pregnancy and safe delivery ()
- (b) Because I fell sick during the pregnancy ()
- (c) To ensure that I delivery in a clinic ()
- (e) I do not know ()
- (f) Other (specify)

15. Did you register with your partner?

- (a) Yes () (b) No ()

16. If no, why not

.....
.....
.....

17. How old was your pregnancy when you first registered for ante natal attendance
.....

18. Have you been consistently attending ante natal clinics?

- (a) Yes () (b) No ()

If not, why.....

20. Do you attend these clinics with your spouse?

- (a) Yes () (b) No () (c) sometimes ()

If not, why

- (a) Did not know it was necessary ()
(b) Spouse too busy ()
(c) Spouse not available ()
(d) Other specify

Section D

21. Do you think your male partners should accompany you to the ante –natal clinic?

- (a) Yes
(b) No

22. Has attending ante- natal clinics with your spouse been beneficial to you as a couple

- (a) Yes () (b) No () (b) not applicable

23. If yes, how

.....
.....
.....

24. If no, why

25. Have you been able to freely communicate with the nursing staff?

- (a) Yes () (b) No ()

26. If no, why

- (a) Feel shy ()
(b) Limited time ()
(c) Health staff is not friendly ()
(d) Other (specify)

27. Do you receive the attention you expect from the health providers at this clinic?

- (a) Yes
(b) No

28. Do you think your male partners should accompany you to the ante –natal clinic?

- (a) Yes
(b) No

29. What do you think must be done by the clinic to encourage male participation in ante natal care?

30. Through what channel is the information you receive given out by this health Centre?

- (a) Radio Mkushi
(b) Health education sessions at ante natal
(c) Drama
(d) Other, specify

Thank you for your cooperation

APPENDIX 2:

Questionnaire for fathers

Section A. Personal information

1. Age

- (1) 12-19()
- (2) 20-35 ()
- (3) 36-45 ()
- (4) 46 and above ()

3. Marital status

- (1) Single ()
- (2) married ()
- (3) widowed ()
- (4) divorced ()
- (5) separated ()

4. Educational level

- (6) No formal education ()
- (7) Grades 1-7 ()
- (8) Grades 8-9 ()
- (9) Grades 10- 12 ()
- (10) Colleges and university ()

5. Can you read and write

(c) Yes () (2) no ()

Section B

5. Have you ever heard of a male involvement in ante natal message in the media?

(b) yes () (b) no ()

6. If yes which media??

(e) Radio

(f) Television

(g) Newspaper

(h) Other, specify.....

7. How often do you listen to ante natal programs on the above mentioned media?

(a) Very often (b) often (c) sometimes (d) rarely

10 what is your source of information on the need for your involvement in ante natal care?

(f) Radio

(g) Television

(h) Newspaper

(i) Health providers

(j) Other, specify

Section C

12. What do you understand by the term male involvement in ante natal?

13. Have you ever heard of this term before?

(a) Yes (b) No

14. Are aware of the need to accompany your partner for ante natal?

15. What is your perception of male involvement in ante natal care
.....
.....

15. What do you think is the importance of men's involvement in ante natal care?.....
.....

14. Do you discuss ante natal issues with your partner?

15. Have you ever accompanied your partner for ante natal clinic?
(a) Yes (b) No

14. Are aware of the need to accompany your partner for ante natal?

15. How old was your partner's pregnancy when you first accompanied her for ante natal clinic
.....

19. Have you been consistently been attending ante natal clinics with your partner

(a)Yes (b) no

20. If not, why

(a)I didn't know it was necessary
(b) Too busy
(d)Other specify

Section D

22. Has attending ante- natal clinics with your spouse been beneficial to you as a couple?

(a)Yes () (b) no () (c) not applicable ()

23. If yes, how

.....
.....
.....

24.if no
why.....

.....
.....

24. Have you been able to freely communicate with the nursing staff at the clinic?

(a)Yes () (b) no ()

25. If no, why

- (a) Feel shy ()
- (b) Limited time ()
- (c) Health staff is not friendly ()
- (d) Other (specify)

16. Do you think ante natal clinics are male-friendly?

(a) Yes () (b) No () (c) sometimes ()

17. If no, why not

.....
.....
.....

26. Do you think it's necessary for you to accompany your spouse to the ante -natal clinic?

.....
.....

27. What do you think are some of the barriers to male involvement in ante natal care in this community

.....
.....
.....

27. What do you think must be done by the clinic to encourage male participation in ante natal care?

31. Through what channel is the information you receive given out by the Health Centre?

- a) Radio ()
- b) Television ()
- c) Newspaper ()
- d) pamphlets/brochures/posters ()
- e) group communication ()
- f) interpersonal communication ()

32. What do you think is the most effective communication method to promote male involvement in this community?.....

Thank you for your Co-operation.

APPENDIX 3:

Communicating male involvement in ante-natal care (MAMAZ)

In-depth interview guide for the coordinator

Pre- interview questions

1. Sex
2. Qualification.....

Interview Questions

1. According to your own understanding what is male involvement in ante-natal care?
2. For how long has your organization been working in Mkushi?
3. What are the issues of male involvement in ante natal care in Mkushi?
4. Is your organisation involved in communicating issues of male involvement in ante natal care? If yes, what issues does your organisation specifically focused on?
5. Has there been any opposition has there been to male involvement in ante natal care?
6. Please describe briefly your organization's work in communicating male involvement in ante natal care in Mkushi?
7. Who are the target audience for your organization?
8. Does your organization include men in any of its maternal health activities?
9. (e.g., as partners of women, as direct clients) please describe.
10. What were the reasons your organization started to work with men?
11. Apart from them also being your target group, in what *other* ways does your organization have contact with men?
12. (e.g., as service providers, policymakers, program managers, or community leaders).
Please
13. Describe.
14. Do the women beneficiaries of your programs want men to be more involved?
15. How?
16. Would your organization like to work more extensively with men in ante natal care?
In what additional ways would you like men to be involved in your maternal health programs?

17. What would make it easier to work more extensively with men?
18. Would it help your organization if there were guidelines provided by the ministry of health on communicating to men on Maternal Health? If yes, how?
19. What are the benefits of involving men in ante natal care?
20. What are the difficulties of involving men in ante natal care?
21. Are there any policies, laws, or regulations that you are aware of as an organisation that are related to male Involvement in ante natal care? If so, which ones?
22. Are there any policies, laws, or regulations that could make it more difficult to involve men in Ante natal care? If so, which ones?
23. Is there anything in the Zambian culture that could be a barrier to male involvement in ante natal care? How do you think these barriers could be overcome?
24. What do you see as the most important components of a program that works with men in ante natal care?
25. To which sources did/do you look for guidance on working with men in reproductive health?(e.g., health workers, traditional leaders, community leaders)
26. How do you create and encourage behaviour change in the community especially where male involvement is concerned using the community mobilisation process that your organisation uses?
27. How do you ensure communities make a transition from increased awareness to sustained change?

Thank you for your Co-operation.

APPENDIX 4:

FOCUS GROUP DISCUSSION GUIDE

INTRODUCTION

Introduce myself: I am a researcher from the University of Zambia conducting a research on the effectiveness of the communication strategies used by the Ministry of Community Development, Mother and Child Health to encourage male involvement in ante natal care. Today the purpose of my visit is to discuss with you issues of male involvement in ante natal care in the community.

This information may help this researcher, the Ministry of Health and other partners understand the subject better and may enable policymakers, program planners, and NGOs to find suitable ways of howbest to improve communication of male involvement in ante natal care issues.

1. What do you understand by the term male involvement in ante natal care
2. Have you all been educated in male involvement in ante-natal care
3. Do you perceive any benefits in couple/ families communication?
4. Briefly explain the activities male partners are involved in at the ante natal clinic
5. 5. What communication strategies do you use as a health centre to promote male involvement in ante natal care in your catchment area?
6. Do you think the strategies currently used are effective in promoting male involvement?
7. if no, do you think there are better strategies or approaches that could be used to promote male involvement in ante natal care?
8. What are the major successes of these strategies?
9. Have there been any major failures?
10. If yes, what are they?
11. What are your facility's future plans in terms communication for male involvement in ante natal care?

- 12.** What do you think are some of the challenges encountered by the health providers in communicating issues of male involvement in ante natal care in this community?
- 13.** What do you think is the best way of communicating the need for male involvement in ante natal care in this community?
- 14.** What message do you send out in the community concerning the need for male involvement in ante natal care?
- 15.** What are some of the barriers when it comes to male involvement in ante natal care? Is it religion, socio-cultural factors or health system?
- 16.** What channels do you use in sensitizing this community on male involvement?
- 17.** What challenges are men facing in complying to male involvement in ante natal care (e.g societal stigma, shyness or embarrassment, nature of job responsibilities, health infrastructure)
- 18.** What do you think should be done to improve community awareness of male involvement in ante natal care?
- 19.** Does anyone have a contribution concerning the issue under discussion?
- 20.** Does anyone have a contribution that is not under discussion but might be relevant to this study?

APPENDIX 5:

Interview guide for the in-depth interview with MCH coordinator.

Pre- interview questions

Sex

Qualification.....

Length of service

Interview Questions

- 1 Briefly state what you know about ante natal care services generally?
- 2 Briefly explain what you know about male involvement in ante natal care
- 3 Briefly explain the activities male partners are involved in at the ante natal clinic
- 4 Have you ever carried out research on percentage of male involvement in the district?
 - Details of the research
 - Percentages
 - Findings
- 5 Does this office give out information to the community on the importance of male partner involvement in ante natal care?
- 6 What medium do you use to communicate this information?
- 7 What messages do you have for?
 - Highly educated
 - Lowly educated
- 8 Do you have any campaigns currently running?
 - Awareness campaigns
 - Behavioural change campaigns
- 9 If yes, how is it been done?
- 10 Are these programs planned and budgeted for?
- 11 What are the objectives of the campaigns currently running?
- 12 Do you think this form of campaigns help to address the problem?
- 13 What communication strategies do you use as an office to promote male involvement in ante natal care in this district?
 - Source

- Channel
- Message
- Audience

- 14 Do you think the strategies currently used are effective in promoting male involvement?
- 15 If no, do you think there are better strategies or approaches that could be used to promote male involvement in ante natal care?
- 16 What are the major successes of these strategies?
- 17 Have there been any major failures?
- 18 If yes, what are they?
- 19 What are your facility's future plans in terms communication for male involvement in ante natal care?
- 20 How do you think you can do things better?
- 21 Do you have any comments on any aspects of what we have been discussing which may be important to this research?

Thank you for your cooperation