NEWPORT INTERNATIONAL JOURNAL OF PUBLIC HEALTH AND PHARMACY (NIJPP)

Volume 3 Issue 2 2023

Factors Influencing the Ineffective Male Involvement in Antenatal Care in Ishaka Municipality, Bushenyi District, Uganda

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ABSTRACT

Male involvement in antenatal care as one of the major aspects of maternal health care is an important strategy in reducing preventable maternal morbidity and mortality worldwide. Due to the low male involvement in antenatal care among other factors, the country continues to have one of the highest MMR at 137 per 1,000 live births. Antenatal care visits are an ideal time to advise mothers with their partners and families on essential pregnancy care to reduce stillbirths and neonatal deaths and develop a birth preparedness plan. The researcher employed a quantitative cross-sectional study design and the study population involved all married men or men who had ever had spouses in Ishaka municipality, Bushenyi district. A simple sampling technique was used. Data was collected using interview-guided questionnaires formulated in English and subsequently analyzed using SPSS 16.0. Data was then presented in the form of tables, pie charts, and graphs. One hundred and twenty males in Ishaka municipality participated in the study. The average age of the participants was 38.0 (SD ± 1.41) and the age range was 17- 75 years. The majority of respondents 46(38.3%) were between the age of 35 and 44 years, 81 (67.5%) Banyankole. The majority of respondents 64(53%) have low levels of knowledge of male involvement in antenatal care. Commonly agreed barriers to male involvement included too much waiting time at the ANC, nature of spouses' occupation, fear of positive HIV results, and long distance to ANC clinic,91(5%),80(66.7%), 68(56.7%), (51.7%) respectively. An enormous number of 85(70.8%) respondents agree that the creation of awareness among men through traditional authorities can promote male involvement in antenatal care. This study concluded that factors influencing male involvement in antenatal care included family Monthly income, distance from health, Alcoholism unit, and level of knowledge of respondents. The majority of respondents had low levels of knowledge of male involvement in antenatal care.Time wasting during antenatal visits was the commonest agreed barrier to male involvement during antenatal visits. The study recommended the need to increase men's knowledge of male involvement in ANC through a massive campaign in Ishaka municipality.

Keywords: Antenatal care, Male involvement, maternal mortality, birth preparedness.

INTRODUCTION

Male (husband) involvement in maternal health is the mental and physical participation of males (husbands) in maternal and prenatal health and family planning in such a way as to increase maternal and infant survival rates and improve family planning outcomes [1-4]. Globally, low male involvement in maternal healthcare services remains a problem for Health care providers and policymakers [5, 6]. For many years, Reproductive Health (RH) issues focused on women in terms of Family Planning, Abortion, management of infertility, and Sexually Transmitted Infections among others [7-11]. Pregnancy and childbirth are privileged functions of women essential for the survival of our species but often accompanied by potential risks that women should be protected from, and this responsibility calls for collective support of the entire family notably the husband, the community, and the state as a whole [12, 13]. Increasing male involvement in maternal health care is an important strategy for reducing

preventable maternal morbidity and mortality worldwide [14]. In sub-Saharan Africa, approximately 69% of pregnant women receive at least one antenatal care (ANC) visit, and 44% receive at least four ANC visits and the full package of key interventions [15-18]. In Kenya, 47% of pregnant women made the recommended four ANC visits [19]. In Uganda, only 48% of mothers make at least four visits [20].

Most cultures, especially in Africa, regard pregnancy and delivery as a female domain; therefore, men are often not expected to accompany their wives to the antenatal care (ANC) clinic or be present during delivery [21]. Men impact women's reproductive health through their role as partners, fathers, and healthcare workers [22]. There has been an increase in reproductive health initiatives that target both men and women in an attempt to fulfill the 5th Millennium Development Goal [23]. However, male involvement has been low, and the lack of progress is a likely contributor to the sub-optimal advancement toward the achievement of the United Nations Millennium Development Goal (MDG) 5: to reduce maternal mortality by 75% between 1990 and 2015 [1]. Despite the numerous documented benefits of male involvement in ANC, Gulu district and Uganda in general have a low prevalence of male involvement in ANC with only 10% of male partners accompanying their wives either for ANC or delivery care [24]. Thus, to improve male participation in ANC, reasons for their poor or reluctant involvement need to be explored.

Aim

To determine factors influencing the ineffective male involvement in antenatal care among men in Ishaka municipality, Bushenyi district, Uganda.

Specific objectives

The following were the operational research objectives;

- To determine men's knowledge of antenatal care
- To identify existing barriers to male involvement in antenatal care

Research questions

The study was guided by the following research questions

- What's the level of men's knowledge of antenatal care?
- What are the existing barriers to male involvement in antenatal care?

METHODOLOGY

Study area

The study was conducted in Bushenyi Ishaka town council Sub County in Bushenyi district. With a total population of 8,190 people, 3,963 males and 4227 females [25]. Major health Centers in Bushenyi Ishaka town council are KIUTH and Ishaka Adventist Hospital. The main economic activity in Bushenyi-Ishaka town council is majorly commercial businesses. However, rearing cattle and growing crops like Bananas are practiced majorly for home consumption. The study area was selected because there are tremendous numbers of women attending antenatal care in the hospital within.

Research design and Rationale

A quantitative cross-sectional study design was used for this study. According to Amin [26], a quantitative cross-sectional study involves measuring different variables in the population of interest at a single point in time. This design was used because it is cheap, quicker, and avoids manipulation of variables [26].

Study population

The study population involved all married men who have ever had spouses in the Bushenyi-Ishaka town council, Bushenyi district.

Sample size determination and Rationale

All the males in Bushenyi-Ishaka town council, Bushenyi district were selected for the study according to Krejcie and Morgan (1970), for a population (N) of 3,963 males [25], the sample size for the given population (S) is 246 respondents.

Sampling technique and rationale

A two-staged cluster simple sampling technique was used. In this study, a cluster is a group of households in the same geographical area. A cluster was between 20 to 50 households. The cluster was selected in the first stage and respondents in the second stage. Firstly, all parishes in the selected part of the municipality and villages within the parishes were listed; one ward and one village were randomly selected from the selected part of the municipality. If the village had less than 20 households, they were merged with neighboring villages to make one cluster with between 20 to 50 households. Clusters were then selected using probability proportionate to the number of

households. Household heads were interviewed within the cluster using interval sampling. The interview was started from the central part of the cluster and household heads were selected randomly. This random sampling method was used because it avoids bias [26].

Inclusion

Males with wives or have ever married or are cohabiting and their partners had given birth to at least one child were eligible for the study.

Exclusion

Males who did not grant consent were ineligible for the study. Males who are not residents of the selected study area and are in the study area too were ineligible for the study.

Data collection instruments

The researcher used a self-administered questionnaire formulated in English and translated into local language whenever necessary. It comprised of mainly three sections, A, B and C and D. The components of section A included the socio-demographic characteristics. On the other hand, the items of sections B and C included both closed and open questions about the information of intended objectives.

Data quality control

To ensure the validity and reliability of the tool, pre-testing was conducted in a different community which was not to be used in the actual study. After pre-testing any variations identified were revised. This was done to ensure that the instruments were suitable to be used within this context thereby collecting data that met the expected objectives.

Data analysis and presentation

Data were edited, coded, and entered in SPSS 16.0 for analysis. The presentation was done by use of tables, graphs, and pie-charts.

Ethical consideration

The researcher was permitted by the faculty of Allied health sciences of Kampala International University through the research coordinator. After permission was granted, the researcher submitted letters to village chairpersons of the selected areas of the various parishes in the Bushenyi-Ishaka town council in the Bushenyi district. After being granted permission, the researcher introduced himself to the heads of the various families for informed consent. The researcher ensured the confidentiality of all the information obtained. The questionnaire was also identified using numbers so to ensure anonymity.

RESULTS

Social demographic data of respondents

Table 1: Showing the age groups of the respondents

The majority of respondents 46(38.3%) were between the age of 35 and 44 years, 44(36.7%) were aged 25-34 years, 24(20.0%) were aged 45 years and above and lastly the minority 6(5%) were aged 18 to 24 years.

Age group	Frequency	Percentage (%)
18-24	6	5.0
25-34	44	36.7
35-44	46	38.3
≥45	24	20.0
Total	**120**	**100.0**

Table 2: Showing tribe of respondents

The lowest number of respondents 3(2.5%) belonged to other tribes, 12(10%) of the respondents were Batooro, and (24%) were Bakiga. The biggest percentage of respondents however constituted the Banyankole 81 (67.5%).

Tribe	**Frequency**	**Percentage (%)**
Banyankole	81	67.5
Bakiga	24	20.0
Batooro	12	10.0
Others	3	2.5
Total	**120**	**100.0**

Occupation of the respondents

Table 3: Showing the occupation of the respondents

The highest number of respondents 42(35.0%) were peasants followed by 38(31.7%) self-employed while civil servant, unemployed respondents made up 14(11.7%), 23(19.2%) respectively. 3(2.5%) were others such as students.

Occupation		**Frequency**	**Percentage (%)**
	Peasant	42	35.0
	self employed	38	31.7
	civil servant	14	11.7
	Unemployed	23	19.2
	Others	3	2.5
	Total	**120**	**100.0**

Bar graph showing frequency against education level of the respondents.

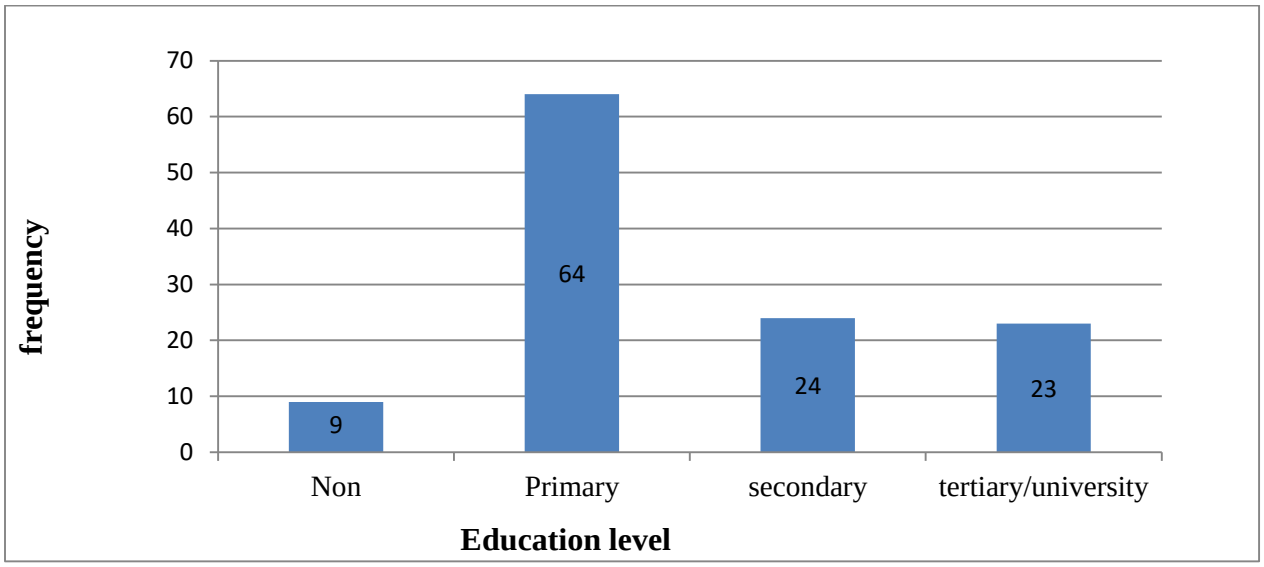

Figure 1: Showing the education level of the respondents

The majority of respondents 64(53.3%) had attained primary education, followed by 24(20.0%)) had attained secondary education, 23(19.2%) had attained tertiary/university education and the smallest number 9(7.5%) had never attained any level of education.

Table 4: Showing the marital status of the respondents

Substantial number of respondents 53(44.2%) were currently married, 25(20.8%) were cohabiting, 19(15.8%) were separated, 15(12.5%) were divorced and lastly 8(6.7%) were widowed.

Marital status	**Frequency**	**Percentage (%)**
Divorced	15	12.5
Currently married	53	44.2
Widowed	8	6.7
Separated	19	15.8
Cohabiting	25	20.8
Total	**120**	**100.0**

Pie chart showing the religion of the respondents by percentage.

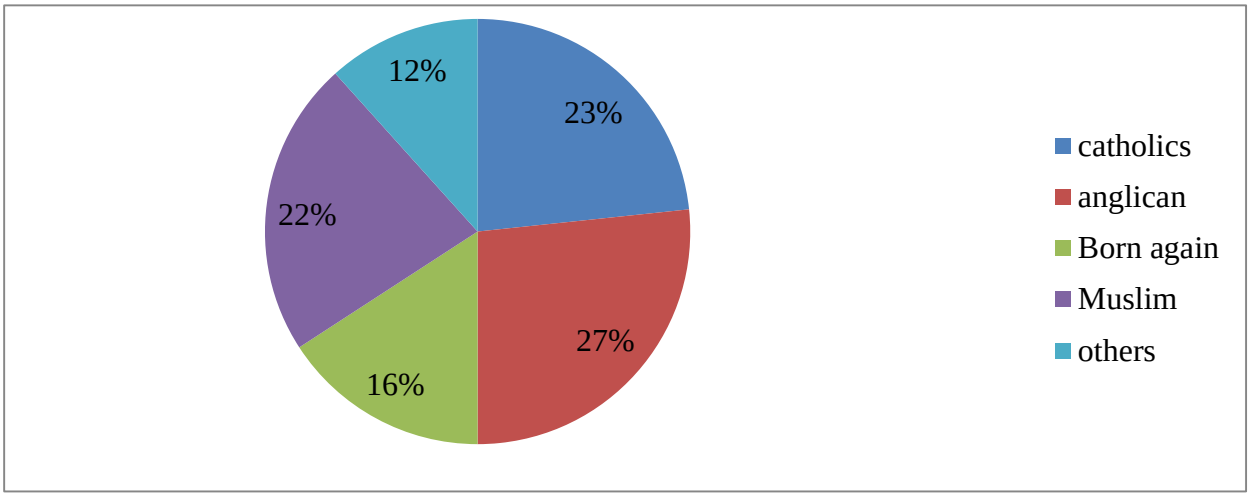

Figure 2: Showing the religion of the respondents

The majority of respondents 32(26.7%) were Anglican, 28(23.3%) were Catholics, 27(22.5%) were Muslims, 19(15.8%) were Born again and 14(11.7%) belonged to other religious denominations or did not have any religion.

Table 5: crosstab analysis of social demographic factors

Variable	Attending antenatal care with spouse (percentage)	Not attending antenatal care with spouse (percentage)

Age		
18-24	8.0	2.9
25-31	46.0	21.0
32-38	30.0	31.0
≥39	16.0	22.9
Religion		
Catholic	26.0	21.4
Protestant	18.0	32.9
Muslim	28.0	18.6
Born again	18.0	14.3
Others	10.0	12.9
Highest level of education		
<Secondary	72.0	52.9
≥secondary	28.0	47.1
Marital status		
Currently Married	38.0	48.6
Divorced	22.0	12.5
Cohabiting	18.0	22.9
Widowed	6.0	7.1
separated	16.0	15.7

Men's knowledge regarding their involvement in antenatal care

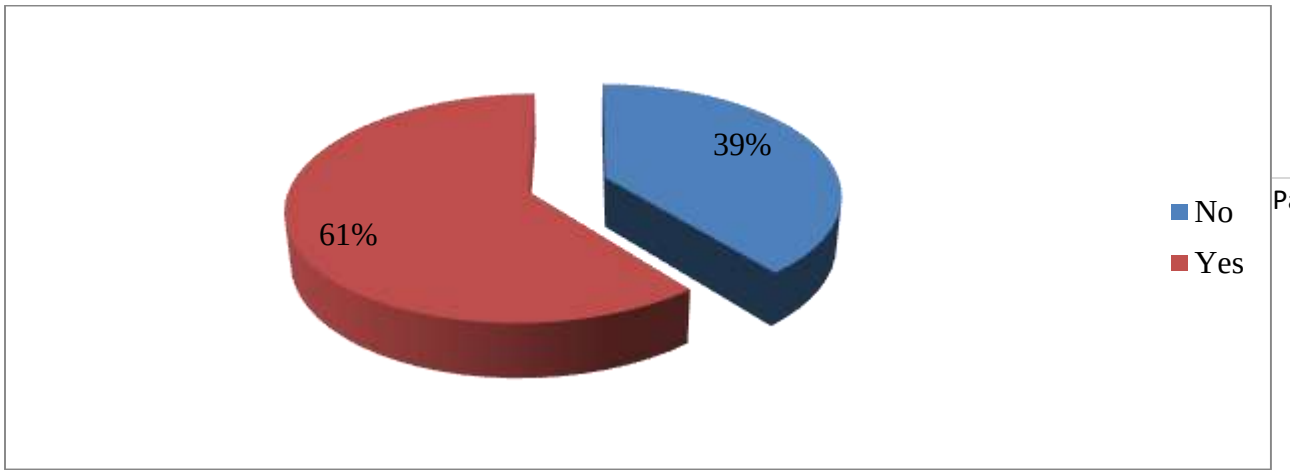

Figure 3: **Showing respondents who have ever heard about male involvement in the religion of the respondents.**

The majority of respondents 73(61%) had ever heard about male involvement in antenatal care.47 (39%) had never heard about male involvement in antenatal care.

How respondents basically understood male involvement in antenatal care.

Of the 73 respondents who have ever heard about male involvement in antenatal care,23(31.5%) understood male involvement as men accompanying their wives for antenatal visits.39(53.4%) did not suggest anything pertaining their understanding about male involvement in ANC.11(15.1%) had other ideas how they understood male involvement in ANC.

A bar chart of frequency against source of information about male involvement in antenatal care.

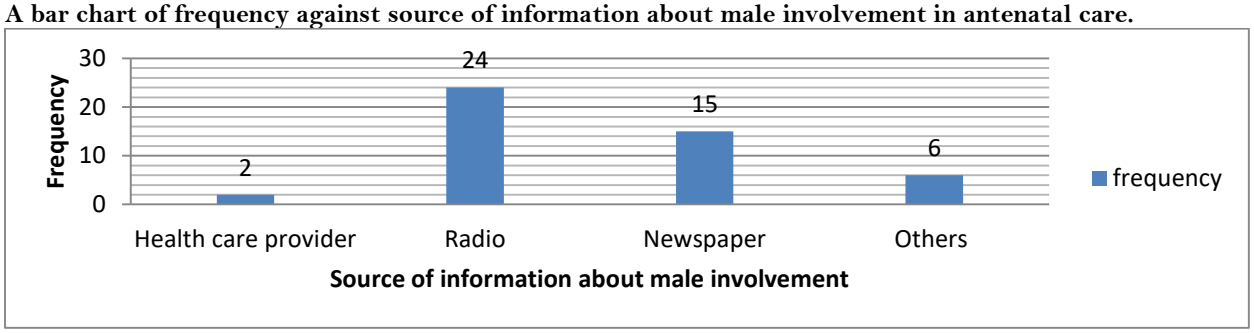

Figure 4: **Showing Source of information about male involvement in antenatal care**

Of the 73 respondents who had ever heard about male involvement in antenatal care, the majority 37(51.1%) reported hearing about it from Radio talks, 23(31.9%) reported hearing about it from Newspapers, 8(12.7%) reported other sources such as public talks while the minority 5(6.8%) reported their sources as health care providers.

Pie chart showing benefits of male involvement in ANC

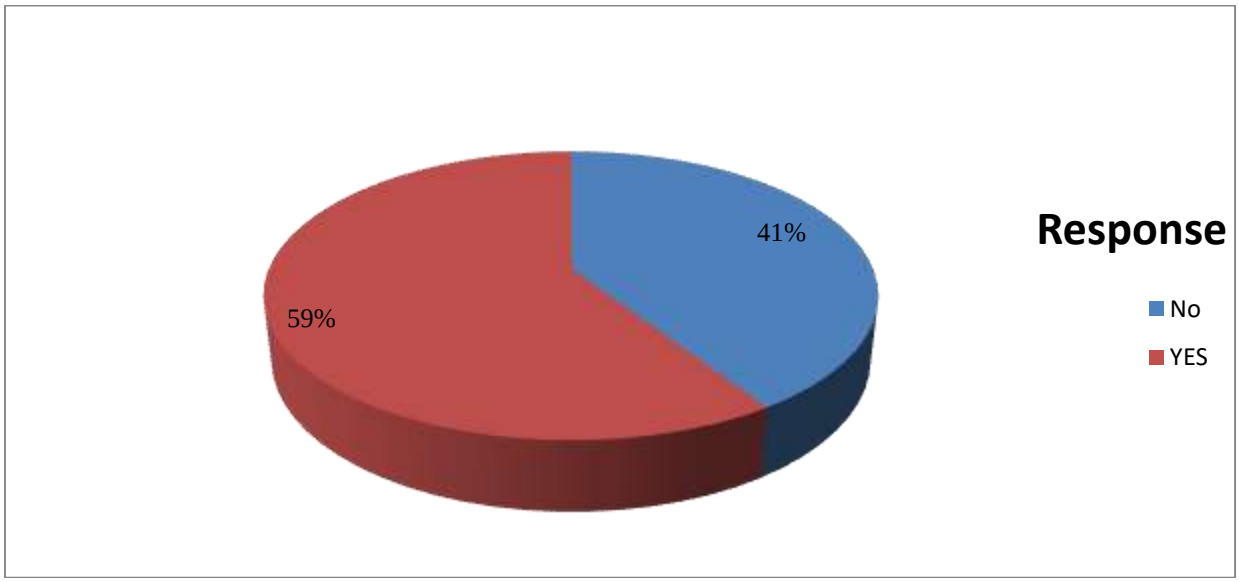

Figure 5: showing whether Male involvement in ANC is beneficial

The majority of males 71(59%) conceded that male involvement in antenatal care is beneficial while 49(41%) of males conceded that male involvement in antenatal care is not beneficial.

Postulated benefits of male involvement in ANC by respondents

Interestingly, the majority participants 71(59%) in Ishaka Municipality reported that it was beneficial to accompany their wives for ANC. seven of the 71 respondents suggested that men getting involved in ANC is a good way to know what's going on with their spouses ."When you are with her it shows contact, you are aware of what is going on there and in case of any complications or even if any referral might be needed, you may decide on what you can do"Other participants (5 of the 71) postulated that male involvement in ANC strengthens love between their spouse and them. "Attending together shows the love l have for her since we are together in all circumstances of life" Some men (3 of the 71 respondents) report discovering their spouse HIV status as merit of getting involved during antenatal visits. "If I go with her to the clinic, we can be tested and get out of there knowing our status of HIV" If one person is positive and another negative then we can be told how to stay together."

Reasons why respondents believe male involvement is irrelevant.

A few of respondents (12 of the 49 respondents) view pregnancy and childbirth as women's responsibility and as such they per take work as more beneficial to them than involving in antenatal care. "Pregnancy and rearing of children are women's affairs therefore most young men are only interested in making babies." Some respondents (8 of the 49 respondents) propounded that they do not learn when they attend ANC since they are not allowed to access examination rooms. As such they would rather remain at home or do other duties. "It's of no use for me to escort my wife for antenatal care when am going to learn anything from the health unit." A trifle of respondents (2 of the 49 respondents) consider male involvement in antenatal care as culturally disrespectful for a man to see a woman giving birth and as such there is no benefit since one is crossing lines with ancestors. "In our culture pregnancy and childbirth is for women, our fathers were not involved in pregnancy issues" Enormous number of respondents (18 of the 49 respondents) believe involving males in antenatal care is a waste of money and time 'Male in involvement in antenatal care is a waste of time and money since my spouse alone can handle"

Barriers to male involvement in antenatal care

Table 8: showing barriers to male involvement in antenatal care

The majority 80(66.7%) of respondents agree that the nature of spouse occupation may serve as a barrier, 26(21.6%) of respondents disagreed that the nature of spouse occupation may serve as a barrier to male involvement in ANC.14 (11.7%) respondents neither agree nor disagree that nature of spouse occupation may serve as a barrier to male

involvement in ANC. The majority 68(56.7%) of respondents agree that Fear of positive HIV test results can bar Men from escorting their wives for ANC.42 (35.0%) disagree that Fear of positive HIV test results bars Men from escorting their wives for ANC.10 (18.3%) of the males neither agree nor disagree that Fear of positive HIV test results can bars Men from escorting their wives for ANC. The majority 74 (61.7%) of respondents agreed that poverty can make men not to escort their partners.24(20.0%) disagree that poverty can makes men not to escort their partners. The minority 22(18.3%) neither agree nor disagree that poverty can make men not to escort their partners. The majority 91(75%) of respondents agree that too much waiting time at the ANC visit can hinder some men from going together with their wives for ANC.19 (15.9%) of the respondent disagree that too much waiting time at the ANC can hinder some men from going together with their wives for ANC.10 (8.3%) of respondents neither agree nor disagree that too much waiting time at the ANC can hinder some men from going together with their wives. The majority 62 (51.7%) of respondents agree that long distances traveled by couples may hinder men from escorting their wives.39(32.5%) of respondents disagree that long distances traveled by couples may hinder men from escorting their wives. The minority 19(15.8%) of respondents neither agree nor disagree that long distances traveled by couples may hinder men from escorting their wives. A substantial number 57(47.5%) of respondents agree that culture in some societies bars some men from escorting their partners for health care services 52(43.3%) disagree that Culture in some societies bars some men from escorting their partners for health care services.19(9.2%) of respondents.

Statement	Response Frequency (percentage)			
	Agree	Disagree	Neither agrees or disagree	Total Frequency (%)
Monogamous can act as barriers to male involvement to attending ANC	15(12.5)	68(56.7)	37(30.8)	120(100)
Polygamous too can act as a barrier	67(55.8)	11(9.2)	42(35.0)	120(100)
Having many patients may make males relax from accompanying their wives	49(40.8)	46(38.4)	25(20.8)	120(100)
Nature of spouse occupation may serve as a barriers	80(66.7)	26(21.6)	14(11.7)	120(100)
Fear of positive HIV test results bars Men from escorting their wives for ANC	68(56.7)	42(35.0)	10(18.3)	120(100)
Poverty Makes Men not to escort their partners	74(61.7)	24(20.0)	22(18.3)	120(100)
Nature of marriage such as cohabiting, polygamous may make men not to escort their partners	21(17.5)	29(24.2)	70(58.3)	120(100)
Age different of couples maybe a barrier to escorting their partners	26(21.7)	44(36.6)	50(41.7)	120(100)
Too much waiting time at the ANC hindering some Men from going together with their wives	91(75.8)	19(15.9)	10(8.3)	120(100)
Bad language used by mid wives makes men fear to escort their partners	45(37.5)	23(19.2)	52(43.3)	120(100)
Education level differences of spouses may be a barriers for them to move together	29(24.2)	40(33.3)	51(42.5)	120(100)
Poor communication between couple may be a barrier for them to move together for ANC services	41(34.2)	30(25.0)	49(40.8)	120(100)
Culture in some societies bars some men from escorting their partners for health care services	57(47.5)	52(43.3)	11(9.2)	120(100)
Long distance travelled by couples may hinder men from escorting their wives.	62(51.7)	39(32.5)	19(15.8)	120(100)

DISCUSSION

Male involvement in reproductive health improves health outcomes, particularly in regard to family planning, antenatal care, and the prevention of mother-to-child transmission of HIV. Men play a role in their partners' reproductive health experiences in multiple ways, from shared decision-making or granting permission for certain services to providing financial support and transport for health services. The average age of the participants was 38.0 (SD ± 1.41) and the age range was 18- 55 years. The majority of respondents 46(38.3%) were between the age of 32 and 38 years followed by 44(36.7%) who were aged 25-31 years. The highest number of respondents 42(35.0%) were peasants followed by the self-employed while civil servants and unemployed respondents made up 14(11.7%) and 23(19.2%) respectively. 3(2.5%) were others such as students. The majority of respondents 64(53.3%) had attained primary education, followed by 24(20.0%)) who had attained secondary education. 23(19.2%) had attained tertiary/university education and the smallest number 9(7.5%) had never attained any level of education.

Substantial numbers of respondents were married followed by respondents who were cohabiting. The current finding is contrary to a report by UBOS [20] in which the majority 49.0% of residents were never married and only 8.8% of residents were married. Generally, the majority of respondents were Christians as depicted in Table 1. This Result from Table 1 may be attributed to Christianity being the first religious denomination to be introduced in Uganda by the missionaries. Generally, in regard to the knowledge of respondents on male involvement in ANC, the researcher graded the respondents into three categories based on the number of questions answered: men with a high level of knowledge on male involvement in ANC ought to have answered 7-10 of the questions correctly, those with moderate knowledge ought to have answered between 4-6 questions correctly and those with low knowledge ought to have answered less than four of the questions correctly. With reference to this grading, the majority of respondents (53%) had low levels of knowledge on male involvement in antenatal care, a substantial number 43(36%) of respondents had moderate levels of knowledge on male involvement in antenatal care and the minority 13(11%) had high levels of knowledge on male involvement in antenatal care. This finding is in consonance with a study by Tweheyo *et al.* [24] in the Gulu district in which knowledge about safe motherhood services among male partners was limited with only 47.1% knowing 3-5 services offered at ANC. Also, another study finding which is in consonance with the current study in which only 19.2% of respondents had attained a higher level of education is a study by Joelle *et al.* [27] in which men with low education levels had significantly lower Knowledge Scores compared to men with a high level of education. According to the current study finding, vast numbers of respondents 73(61%) have ever heard about male involvement in antenatal care. This could be due to the ongoing campaign aimed at promoting male involvement in HIV/AIDS and STI prevention. Of the 73 respondents who have ever heard about male involvement in antenatal care, a trifle of respondents 23(31.5%) understood male involvement as men accompanying their wives for antenatal visits whereas 53.4% of respondents had no idea pertaining to their understanding about male involvement in ANC. This finding could be due to illiteracy or less use of social media to enlighten the community members about male involvement in ANC. Of the respondents who had ever heard about male involvement in antenatal care, the majority of participants 24(51.1%) reported hearing about it from Radio talks. Others included Newspapers and public talks. This finding could be due to most respondents having radios at home compared to other sources such as newspapers. In a similar study by Alio et al. [28], most respondents heard about ANC and PMTCT through radio messages, adverts, and motivational talks. Interestingly, some participants (59%) in Ishaka Municipality conceded that it was beneficial to accompany their wives for ANC. The suggested merit included getting to know what's going on with their spouses and involving in decision-making such as signing consent for surgery. Other respondents believe male involvement in ANC strengthens the love between them and their spouses. Furthermore, some respondents reported discovering their spouse's HIV status as a merit of getting involved during antenatal visits. Other respondents saw getting involved in antenatal care as a way of getting first-hand information about the health of their wives and unborn babies. Of the 41% of the respondents who conceded that male involvement in ANC is irrelevant. A bevy of the respondents (12 of 49) view pregnancy and childbirth as women's responsibility as such they take work as more beneficial to them than involving in antenatal care. This current study finding is concurrent with Byamugisha *et al.* [29] which reiterates this finding. In their findings, frequently men perceive ANC services as designed and reserved for women, thus they are embarrassed to find themselves in such "female" places "Everyone has his or her role to play in the family" A few respondents (8 of the 49) propounded that they do not learn anything when they attend ANC since they are not allowed to access labor or examination rooms. As such they would rather remain at home or do other duties."The doctors do their things behind closed doors and leave me in suspense at the end of the day"A trifle of respondents (2 of the 49 respondents) considers male involvement in antenatal care as culturally disrespectful to men. "There are better things a man can do rather than low himself to escort his wife" This finding is in consonance with Msuya *et al.* [30] in which men who accompanied their wives for ANC services were perceived as being dominated by their wives. An enormous number of respondents (18 of the 49) believe involving males in antenatal care is a waste of money and time. "I would rather do other precious activities since it makes no difference to escort my wife for a check-up" This finding is concurrent with a study by Byamugisha *et al.*, [29] in which Men considered attending antenatal together as a waste of time. Time wasting during antenatal visits was one of the commonly agreed barriers to male involvement during antenatal visits. The majority of males reported they were too busy for such tasks, particularly as long queues meant delays in being seen and too much time wasted during the antenatal visits. Most men in paid workforces prioritized their time on economic activities and those without on farming. Similar findings have been reported in other studies [29, 31]. Possibly men can be encouraged to attend ANC by opening antenatal clinics on Saturdays-Sunday when most men who are in paid jobs are at home. However, many of the local population in this current study are subsistence farmers which may limit their attendance. The majority of respondents agreed that the nature of spouse

occupation may serve as a barrier to male involvement in ANC. Other authors have agreed with this study finding [32, 33]. The majority of respondents in the current study agreed that the financial constraints of men can hinder their participation in ANC. This finding is similar to several other studies in which financial constrain are reported as a barrier to male involvement in ANC [31, 30, 33]. Respondents in the current study commonly agreed that fear of receiving an HIV-positive result can prevent males from coming for antenatal services together with their spouses. This is concurrent with many studies in which males were mentioned to be concerned about HIV-associated stigma and disclosure [33, 34]. In other studies, in which respondents were women, they mentioned the discovery of a positive HIV status as leading to violence, abandonment, rejection, or being perceived by their spouses as being responsible for bringing HIV into the couples' relationship [34, 35]. In contrast, Tweheyo et al. [24] study in Uganda revealed that men were more likely to accompany their spouses for ANC if there were voluntary counseling and HIV testing services offered during the visits. Therefore, it is important, during the initial ANC attendance and any community health education, to ensure that men in the community understand that HIV counseling and Testing is voluntary. Furthermore, discussing HIV test results with the partners, encouraging partners to be supportive regardless of the HIV test results, and encouraging male participation in couple counseling and willingness to accompany their spouses for ANC could be of benefit in reducing the fear of receiving an HIV positive result. Another barrier stemmed from the long distance traveled by most couples to the health centers for ANC. Several studies also reveal a lack of transport and long distances to ANC clinics as a barrier to men escorting their wives to ANC [36]. A substantial number of respondents in the current study agreed that culture can bar some men from escorting them from attending ANC with their spouses. In this current study, some men believed that it is culturally disrespectful for a man to see his wife giving birth, others echoed that their spouses need privacy during antenatal visits while others considered escorting their spouses for ANC as a foreign practice. This finding is concurrent with vast study findings in which culture hindered males from involving in antenatal care [33-45].

CONCLUSION

Factors influencing male involvement in antenatal care included family monthly income, distance from health centers, heavy alcoholism, and level of knowledge of respondents. The majority of respondents had low levels of knowledge of male involvement in antenatal care. Time wasting during antenatal visits was the commonest agreed barrier to male involvement in ANC. Others included the nature of the spouse's occupation, financial constraints, fear of receiving an HIV-positive result, and long distance traveled by most couples.

RECOMMENDATION

- There is a need for health education to increase men's knowledge of male involvement in ANC through mass campaigns in Ishaka Municipality.
- There is a need for government to set up more health centers in the rural areas.
- Massive sensitization of the masses in Ishaka against the dangers of alcoholism.

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