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Perceptions and Experiences of Young Pregnant Women Aged 15-19 years on Low Male Involvement at Antenatal Care Clinics and PMTCT Services in Mwense District, Luapula, Zambia

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Abstract

Background: Male involvement in antenatal care clinic is defined as the male partners' active engagement in the antenatal care services. Men work as doorkeepers to women's admittance to reproductive health services and male involvement in antenatal care and HIV testing assist to reduce infant HIV infection and escalations HIV free survival in children. Nonetheless, male participation has been low in Zambia, particularly amid partners of young pregnant women. The study aimed to investigate the perceptions and experiences of young pregnant women on male involvement at antenatal care and to assess their acceptability of male involvement at antenatal care.

Methods: The study was conducted in Mwense District of Luapula province. Phenomenological design and purposive sampling were used. Three focus group discussions and thirty in-depth interviews were conducted. Thematic analysis was used. Analysis of data was done manually. Some themes were deductively coded from the interview guides, conceptual framework and objectives of the study while some were processed inductively from the data transcriptions. Triangulation helped to check for consistency and potential variations of findings.

Results: Generally, young pregnant women perceived male involvement at antenatal care clinics as a good service. Male participation among young pregnant women was highly acceptable but with low utilization. It was perceived to help couples prepare for delivery, increase love and care, and learn more about HIV. Male participation was considered helpful for a healthy pregnancy and safe delivery. The participants felt the need for programme continuity. Male participation helps to handle some of the home challenges that come when the female attend antenatal care alone. Providing targeted male antenatal care information meetings may also increase male partner participation. The young women's experiences were mixed, ranging from a better and quick service if accompanied, to being scolded and delay in being attended to if they not escorted by a partner.

Conclusion: Male participation left young pregnant women with both negative and positive experiences. The negative experiences led them to bad perceptions while positive experiences helped the young women appreciate the programme as working to their benefit hence the desire to have it continue. Community-based packages that would encourage male participation and minimise related stigma need to be commenced. Male-friendly antenatal care services should be established. Male targeted programmes that inspire men to attend antenatal care clinics should be considered. Future studies on views of men with young pregnant partners and their perception on male involvement are recommended. This would aid formulating targeted interventions.

Keywords: Perceptions; Experiences; Young pregnant women; Male involvement

Abbreviations

AIDS: Acquired Immunodeficiency Syndrome; ANC: Antenatal Care; ARV: Antiretroviral; DMO: District Medical Office; EMTCT: Elimination of Mother-to-Child Transmission; FGD: Focus Group Discussion; FHI: Family Health International; HIV: Human immunodeficiency virus; IDI: In-Depth Interview; MCH: Maternal and Child Health; MI: Male Involvement; MoH: Ministry of Health; MTCT: Mother-to-Child Transmission; PEPFAR: United States President's Emergency Plan for AIDS Relief; PMTCT: Prevention of Mother-to-Child transmission (of HIV); UNAIDS: Joint United Nations Programme on HIV/AIDS; UNFPA: United Nations Population Fund; UNICEF: United

Nations Children's Emergency Fund; UNZABREC: University of Zambia Biomedical Research Ethics Committee; USAID: United State Agency for International Development; VCT: Voluntary Counselling and Testing.

Background

Male involvement (MI) in (antenatal care) ANC is defined as the male partners' active participation in attending ANC services and Human Immunodeficiency Virus (HIV) testing during the antenatal period as well as the couple's approval of Prevention of Mother-to-Child Transmission (PMTCT) if the mother is found to be HIV positive [1]. MI helps men and their families to get into HIV preventive and care services. It is a significant recommendation for the PMTCT of HIV programmes because involvement of the male folk in ANC and HIV testing which has been found to reduce infant HIV infection and escalate HIV free survival [2]. A number of services are offered during an ANC visit and HIV testing is among them particularly in countries with a high HIV burden [3].

Men are traditionally not directly involved in their partner's health in Africa even if most of the time they influence decision making about use of services by the family members. In most cases, men may provide financial support but attending health services with their partner is not seen as part of the male's role. In some countries, the rates are much higher; 15% or more of young women in Botswana, South Africa, Swaziland and Zimbabwe are living with HIV [4]. Whereas women in Sub-Saharan Africa are now less likely to be married in their teenage years than they were in the past, a considerable fraction of women still marry at a young age [5]. Even though rates differ significantly from country to country, approximately four in 10 women in Sub-Saharan Africa marry before turning 18 and six in 10 women do so by age 20. Consequently, there are enormous challenges in efforts to get men involved in reproductive health services and there is a need to better understand how to promote male participation in various locations. Antenatal care services need to be more "male-friendly" to inspire more men to show up with their partners [6].

According to Benkele, the HIV/AIDS epidemic has not only led to high morbidity and mortality among Zambians, nonetheless it continues to pose a great challenge on the Zambian economy [7]. Zambia has one of the top HIV prevalence rates in the world, with an adult HIV prevalence rate of 12.5% (11.9% in men and 13.3% in women) [8]. Nearly one out of ten new infections take place in children aged 0 to 14, most of which are due to vertical spread. HIV prevalence remains high at 13.3% amid pregnant women [9]. There were 2,946 new HIV infections among children aged 1 to 4 in 2011. Only 28.2 of children aged 0-14 years have been put on antiretroviral therapy compared to 90.0% among adults 15 years and older [10]. Owing to funding from the President's Emergency Fund for AIDS Relief (PEPAR) of the United States government, there was a dramatic upsurge in PMTCT service coverage between 2008 and 2011. PMTCT services are now offered at nearly every service delivery point for ANC in the country [11]. Some 11% of all births worldwide are due to girls aged 15 to 19 years, and the massive majority are in low- and middle-income countries [12]. The 2014 World Health Statistics put the global adolescent birth rate at 49 per 1000 girls. Young people in Africa are much more likely to be living with HIV than adolescents in other regions around the world [13]. Across Sub-Saharan Africa, HIV is increasing all over the general population. Approximately 4.3% of women aged 15-24 in Sub-Saharan Africa are living with HIV, compared with 1.5% of men in that age-group [14].

On the other hand, to some extent more than one in 10 men in Sub-Saharan Africa marry before turning 20. Zambia is home to over 800,000 Orphans and Vulnerable Children (OVC) 0-17 years of age due to AIDS. Four in ten children under age 18 are not living with both parents; and 15 percent of children under age 18 are orphaned, one or both parents are dead [15]. This state of affairs makes it imperative to consider the importance of male participation at antenatal clinic in this vulnerable age group. Wider knowledge about Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) is lowest among young women and men age 15-17 (35 percent and 40 percent, respectively) and Mother-To-Child Transmission (MTCT) knowledge is lowest among the youngest respondents (age 15-19) (62 percent of women and 44 percent of men) [16]. It also shows that 80 percent of women age 15-49 have been tested for HIV. Merely 2 percent of women who had been tested for HIV did not receive the test results. The percentage of women who have been tested for HIV is lowest among those aged 15-19 (49 percent), those who have never been married and never had sex (32 percent), those with no education (77 percent), and those in the lowest wealth quintile (77 percent). This study aimed to determine the perceptions and experiences of young pregnant women on male involvement at antenatal care clinics and to assess their acceptability of male involvement at ANC.

Methods

The study was conducted in Mwense district of Luapula province. The district has 13 health centres and 5 health posts. Since there is no district Hospital, first level hospital services are provided by hospitals from the neighbouring district, which are Mansa General and Mbereshi Mission Hospital. Mwense is a rural district. A qualitative simple exploratory approach was used to examine the views and experiences of young pregnant women aged 15-19.

Nine health facilities were sampled conveniently. All pregnant women aged 15-19 years attending ANC in the selected sites during the time of data collection were asked to participate in the study. Consenting women regardless of the gestation age and the number of ANC visits a woman had had in that pregnancy were incorporated in the study. The sample comprised of thirty young pregnant women aged 15-19 years for in-depth interviews (IDI), which had sixteen married women and fourteen unmarried women. It also included three focus group discussions (FGD) that included maximum of ten young pregnant women aged 15-19 years per group from three health facilities. The three health facilities where the focus group discussions were held were purposively selected

from the remaining facilities that were not picked for in-depth interviews.

Data Collection

Data was collected by the principle researcher with the help of seven (7) research assistants who were trained before going for data collection. The interviews followed an IDI guide. To complement insights from the interviews, three FGDs consisting of 10 individuals were undertaken with different pregnant women of the same age identified from the antenatal clinic in the health facilities of the District to capture their perceptions. A semi-structured IDI guide and a FGD interview guide were used to gather detailed information from participants using the local language commonly spoken in the area. The interview guides were formulated in English and translated into Bemba. Back translation was done into English to check for consistency by a trained teacher. A tape recorder was used in both IDIs and FGDs. A total of thirty IDIs were conducted with young pregnant women aged 15-19 years. All participants attended only one individual interview, which lasted for 30-45 minutes. Open-ended questions and inductive probing were adopted during the data collection process. This enabled us to make clear expressions or meanings of the young pregnant women's daily experiences at home and communities, and further allowed them to freely tell their stories. In addition, observations of non-verbal cues were done by the researcher.

Data Management and Analysis

All interviews were recorded digitally and later transcribed verbatim. Analysis was manually done and started while in the field. Thematic analysis, which involved identification of shared themes and issues, was used to analyse data. Thematic analysis was used as it is good for research, since it is less theoretical [17]. The first stage was familiarisation. This was the processes of gaining a general idea of the collected data. It involved absorption in the data through reading and re-reading of transcripts. After familiarisation, came the generation of codes. A code is a word, phrase or sentence that denotes aspects of a data or captures the essence or features of the data [18]. The coding process involved matching of codes with segments of text/informant statements selected as representative of the code [19]. During the coding process, substantial emphasis was placed on returning the original meaning of what was communicated by the informants.

The next level involved searching for themes among codes. The first step in this level was categorization. This involved grouping the coded segments into 'Subthemes' based on similarity of content. This was done in order to reduce the number of different pieces of data in the analysis. In this light, similar codes were grouped together to form categories. The groups of content were evaluated to assess if generalisations could be made. Thus, major themes were established by interpreting the groups for their underline meaning. Themes in this case were the higher level of categorization that was used to recognize the major elements while the entire analysis of the data. A theme can thus be said to be a product of coding, categorization and analytic reflection [20]. By using this analytical strategy, participant's perceptions were explored as well as the broader social environmental context that may influence them.

With regard to ethical consideration, since the study involved human beings, it was important to obtain consent to undertake this study from designated research and ethics committee and to the participants who were allocated. In view of this, the researcher got the approval from Excellence Research Ethics (ERES) (I.R.B. No. 00005948; E.W.A. No. 00011697, reference number, 2015-June-014) [21]. The summary of the study and the objectives were presented before seeking informed consent from the participants. Care was taken to ensure that ethical principles of informed consent, confidentiality and anonymity were observed.

Eligible participants were given an information sheet in Bemba or English, depending on their language of preference, which explained the purpose and nature of the study and the contact details of the researcher. Assent to participate in the study was obtained from participants below the age of 18 and consent was also sought from the parents/guardians/husbands to permit their children or dependants to participate in the study. Those 18 years old and above were able to consent on their own. There were no direct benefits for the participants but rather, their participation contributed to scientific knowledge.

Results

A total of 30 young pregnant women participated in the study. The age of the respondents was from 15 to 19 years old. Fourteen of the respondents were 19 years. The respondents who were 18 years were eight. One respondent was 15-year-old, three were 16 years and four were 17 years (**Table 1**).

Table 1: Response from the young pregnant women age between 15-19.

S/No	Variable		Frequency	Percentage (%)
Total			30	100
1	Age	15	1	3
		16	3	10
		17	4	13
		18	8	27
		19	14	47
2	Marital status	Married	16	53
		Not married	14	47
3	Marital year	2013	1	6
		2014	6	38
		2015	9	56

4	Number of children	No child	27	90
		One child	3	10
5	Education level	Never being to school	1	3
		Lower primary school	2	7
		Upper primary school	12	40
		Junior secondary school	14	47
		Senior secondary school	1	3
6	Occupation	Farming	22	73
		Business	3	10
		Doing nothing	3	10
		Fishing and piece works	1	3
		Farming and business	1	3
7	Guardian	Husband	15	50
		Parents	9	30
		Mother	5	17
		Sister	1	3

Married respondents were sixteen and unmarried respondents were fourteen (**Table 2**).
Twenty-seven out of thirty respondents had no children (**Table 2**).

There was one respondent who has never being to school, two respondents attended lower primary school and twelve respondents attended upper primary school. Fourteen respondents attended junior secondary school and only one respondent attended senior secondary school (**Table 2**).

Twenty-two respondents survived on farming, three respondents were doing business, one-tenth respondents had nothing to do, one respondent was engaged in fishing and piece works while another respondent was doing farming and business (**Table 2**).

Findings from this study have shown that half of the respondents were living with their husbands, nine respondents were living with their parents, five respondents were living with mothers while one respondent was living with the sister (**Table 2**).

Although, the analysis is presented like a linear process, it should be emphasised that it involved a continuous shifting back and forth between the different data sets as well as between the participants' narratives and the researchers' interpretation of the meanings of the material [22].

Factors and themes.

Major factors	Themes
Perceptions	Negative attitude of men and women
	Most service providers are women
	Lack of information / ignorance
	Myths and misconception
	Men's superiority complex
Experiences	Attitude of health workers
	Quality of care
	Waiting time
	Availability of health workers
	Availability of services
	Affordable services/cost
	Accessibility of services
Acceptability	Poor communication among spouses
	Traditional belief

Perceptions

The themes that emerged from the data under perceptions were the negative attitude of men and women; most service providers are women; lack of information or Ignorance; myths and misconception and men's superiority complex.

Negative attitude of men and women

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

M: Why do you leave your partners behind?

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

Most service providers are women

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

M: What is the benefit of male involvement?

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

Lack of information/ignorance

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

M: What is male involvement?

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

R9: I see male involvement as the process at ANC clinic that involves testing for HIV, receiving teachings and help to prepare for delivery. I have found that MI assist me to relate well with my husband especially in regard to our HIV/AIDS status and preparing for our upcoming baby. My husband has proven to be helpful in many ways such as reminding me on what we were taught at the clinic when I express ignorance. The findings have shown that the respondents got information about MI from the clinic, community, radio, television and parents. Findings have also shown that they got information from registered pregnant women and mothers. One woman said this in confirmation;

M: Where do you get information about male involvement?

R3: I hear from the people in our community who have been to the clinic for ANC before. I also hear it from the radio and television once in a while. When I came to the clinic, I received more information about MI in a well packaged manner. Findings of this study have shown that the respondent accessed information from the Health staff at the clinic, pregnant women, mothers while and parents. One of the respondent had this to say; M: How did you access information about male involvement?

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

Knowledge of the respondents on male involvement is not adequate. One respondent expressed herself as follows;

M: How adequate is your knowledge on male involvement?

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

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

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

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

Another respondent had this to say;

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

Myths and Misconceptions

The study showed that there are a lot of beliefs that hinder the participation of men in antenatal care clinic. Some of the participants disclosed that they were taught from childhood that antenatal care services are not meant for men because everything that take place there do not concern men. Findings have shown that participants perceived pregnancy as a responsibility of women. Pregnancy was perceived as a responsibility of both men and women. They put it this way;

M: Whose responsibility is pregnancy?

R1: Pregnancy is purely a women's issue.

R5: Pregnancy is for both men and women.

Men's superiority complex

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

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

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

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

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

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

Findings of this study have shown the participants desired that men should carry cassava from the field, prepare the needs of the baby, provide sexual satisfaction, encouragement,

clothing and groceries. This was expressed through the following quote;

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

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

Attitude of health workers

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

M: What are your concerns about male involvement?

R: It is very difficult for me to convince my partner to escort me for ANC visit because he is still in the boarding school which is not in this area. So I have no choice but to go alone to the clinic and plead with them (health staff) to help me in his absence.

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

M: How would these concerns be addressed?

R: I think that the challenges I face now to convince my husband to accompany me for ANC clinic can reduce by involving elderly people who can easily talk to my husband when he refuses to with me.

Accessibility of services

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

M: What is your experience about the service provided?

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

Cultural Factor as Experience

Poor communication among spouses

Findings of this study have shown that participants experience barriers against involving their male partners in ANC. Communication breakdown has been pointed out to be a major issue with respect to participation of male partners in antenatal activities. If the couple is not in talking terms, it proves to be difficult for the woman to convince her partner to accompany her to the clinic for ANC. This was evidenced by the following quote;

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

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

Traditional belief

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

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

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

Types of barriers experience

Regarding barriers of MI experienced by young pregnant women at antenatal care clinic, the respondents cited ignorance. Other barriers cited were fear for HIV test and work while some respondents felt that it was deliberate that some men did not attend antenatal care clinic. Barriers to male involvement were mainly at the level of the society, the health system and the individual. Health system factors such as long waiting times at the antenatal care clinic and the male unfriendliness of PMTCT services were also identified. It was discovered that the fear for HIV/AIDS test by men was a barrier to male participation at ANC clinic. The participants indicated that their male partners were not willing to under Thus, men feel that there is no reason for a premature investigation of their HIV status, at least not until they are very ill and AIDS is suspected. Even when AIDS is suspected the first line of resort is the traditional healer [23]. It is estimated that 70% of the population in SubSaharan African accesses traditional healers as their first choice of health care. Traditional healers are held in high esteem as they are thought to provide the spiritual interventions required to bring about health improvements [24]. Although it has been demonstrated that traditional healers are able to incorporate HIV prevention in their clinical practice, there are challenges to successful collaborations between traditional and biomedical sectors [25].

Secondly, a man accompanying his wife for ANC raises curiosity in the community about the results of the HIV tests, whether or not the tests were taken. This curiosity is raised because of the multiple sexual partnerships, results of one individual are a proxy indicator of the HIV serostatus of another sexual partner [26]. Multiple concurrent sexual partners have been identified as one of the drivers fueling the HIV epidemic in Uganda and that in central regions of Uganda, men were likely to have more than eight sexual partners in their lifetime; the number of sexual partners increased with

increasing wealth quintiles [27]. These partnerships are an impediment to male participation in HIV prevention services, as observed in this study; and as previously noted there has been insignificant funding for interventions that address underlying social norms [28]. Thirdly the fact that the male partner has tested with the wife will mean that he has to disclose to the wife, yet men traditionally disclose to their fellow men. Fourthly, fear of stigmatization in case of positive HIV test result is a deterrent for both men and women alike [29].

Fifthly, although disclosure has resulted in partner support of adherence to PMTCT recommendations elsewhere from experience women know that disclosure of an HIV test result raises further questions on the reasons why they decided to take the test, and often has led to disruption of marriages; therefore women are reluctant to request their partners to participate in programs that require HIV testing, or even to present letters of invitation from the health facility because they would have to explain how they got to the facility, and what they shared with the health workers, leading to the invitation [30].

Previous studies have also found that men are uncomfortable with reversed role of women as bringers of health information to the home and would prefer other men to provide such information. The decision to take an HIV test is therefore one that is thought over very carefully and cannot be made instantly in a setting where no clear benefit for the man is at hand [31]. Therefore, as long as male involvement in ANC simply means that men accompany their partners and undertake an HIV test, then men will continue to resist participating in this program since it disrupts their social networks. At the level of the health system these findings imply there is a need for reinforcement of the strategies used, if any, to improve male involvement in ANC clinics. There is need to actively invite and involve men in ANC activities through different means [32]. These efforts of engaging men should consider the health and other needs of men rather than simply portray them as tools for women's or infant's health outcomes.

Morfaw et al. identified 24 studies from peer-reviewed journals; 21 from sub-Saharan Africa, 2 from Asia and 1 from Europe. In this study, barriers to male involvement in PMTCT were mainly at the level of the society, the health system and the individual. The most pertinent was the societal perception of ANC and PMTCT as a woman's activity, and it was unacceptable for men to be involved. Health system factors such as long waiting times at the antenatal care clinic and the male unfriendliness of PMTCT services were also identified. The lack of communication within the couple, the reluctance of men to learn their HIV status, the misconception by men that their spouse's HIV status was a proxy of theirs, and the unwillingness of women to get their partners involved due to fear of domestic violence, stigmatization or divorce were among the individual factors [33].

Acceptability

In regard to general acceptability of men's presence during antenatal care visit, it was generally acceptable for men to be present during ANC clinic. It was not culturally acceptable in the community for men to be present during delivery of their partners. It was clear that improvement of ANC services by making them more male friendly, and health education campaigns to change beliefs and attitudes of men are absolutely needed [34]. Several studies have reported negative perceptions towards men attending ANC services. In one report, men who accompanied their wives to ANC services were perceived as being dominated by their wives [35]. Frequently men perceive that ANCs services are designed and reserved for women, thus are embarrassed to find themselves in such "female" places [36].

Certain women too, do not like to be seen with their male partner attending the ANC service. A study conducted in Kenya showed that certain male clients trust traditional healers but not hospitals and therefore do not attend ANC clinics [37]. In this study, with respect to pregnant women's acceptability of men's presence during delivery, the study found that the participants do accept the presence of men at ANC clinic. In view of Health Staff's acceptability of men's presence during ANC, the participants disclosed that it is acceptable to staff for men to be present during ANC.

Limitations of the study

The following were the limitations of this study;

The non-involvement of men in the study that are within the desired age range of 15 – 19 years as their perception might vary with those of young pregnant women of the same age range.

This study was conducted in Mwense district of Luapula province setting. The findings can reflect the views of young pregnant women in that setting but may not reflect the views of young pregnant women in other settings.

In addition, ascertaining the genuineness of responses provided by the study participants is a daunting challenge in research and this study has no exception.

The analysed information had been translated into English, which could have diluted the original richness of the data including possible loss of information. This was however minimized by ensuring that translation was done by experienced data collectors as soon as each interview was accomplished.

Convenient sampling was used which may not give the most suitable sample for the study.

Conclusion

In conclusion, young pregnant women perceived male involvement at antenatal care clinics as a good programme. Male involvement was highly acceptable but with low utilization. It was perceived to help couples prepare for

delivery, increase love and care, and learn more about HIV. Male involvement was considered helpful for a healthy pregnancy and safe delivery. The participants felt the need for programme continuity. Male-friendly antenatal care services should be developed. The young women's experiences of male involvement were mixed, ranging from a better and quick service if accompanied, to being scolded and delay in being attended to if they were not accompanied by a partner. Male involvement left young pregnant women with both negative and positive experiences. The negative experiences made them to have bad perceptions while positive experiences helped the young pregnant women appreciate the programme as being to their benefit hence the desire to have it continue. Community-based programs that would promote male involvement and minimise associated stigma need to be initiated. Male targeted programmes that encourage men to attend antenatal care clinics should be considered. Future studies on views of men with young pregnant partners and their perception on male involvement are recommended. This would aid formulating targeted interventions for the programme.

Competing Interest

The authors declare that they have no competing interests.

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Availability of Data and Materials

The datasets supporting the conclusions of this article are available in the University of Zambia library. Access to data is given upon approvals from the University and permission from all data providers.

Author's Contributions

The data was collected and analysed by the first author with approval from the other authors. The first author drafted the manuscript with the assistance of the other authors. All the co-authors gave advice on the data analysis, presentation of the results, reviewed and edited the text and approved the final manuscript.

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