

Knowledge, Attitude, and Practice Regarding Antenatal Care Among Husbands Attending Antenatal Clinic in a Tertiary Care Hospital of Rewa City

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Abstract: **Introduction:** Antenatal care (ANC) plays a pivotal role in reducing maternal and neonatal morbidity and mortality. Traditionally, pregnancy and maternal health have been considered solely the responsibility of women, yet growing evidence highlights the importance of male involvement in improving health-seeking behaviour and compliance with ANC recommendations. In patriarchal communities like India, husbands' knowledge, attitude, and practices (KAP) significantly influence maternal outcomes. This study aims to assess KAP regarding ANC among husbands accompanying their wives to a tertiary care antenatal clinic. **Objectives:** To assess the knowledge of husbands regarding ANC, evaluate their attitude towards maternal health and antenatal visits, determine their practices, and identify socio-demographic determinants influencing KAP. **Materials and Methods:** This cross-sectional observational study was conducted at the antenatal clinic of Shyam Shah Medical College and Associated Sanjay Gandhi Memorial Hospital, Rewa (M.P.). A total of 150 husbands attending ANC clinic were interviewed through a pre-tested, structured questionnaire. The results were drawn using MS Excel and appropriate Statistical tests. **Results:** Among 150 husbands, 62% were aware of the need for ANC check-ups, but only 37% knew that at least four visits are recommended. Knowledge of tetanus immunization (59%) and danger signs (53%) was moderate, while awareness of iron-folic acid (77%) and the importance of a nutritious diet (89%) was high. Attitudes were largely favourable, with 72% acknowledging their responsibility and 67% supporting ANC accompaniment, though 21% still perceived ANC as uneconomical. **Conclusion:** Promoting male engagement in ANC is critical for achieving better maternal and neonatal outcomes. This study will provide insights into existing gaps and guide policymakers to design male-inclusive health education interventions that strengthen family-centred maternal care.

Keywords: Antenatal care, Maternal health, Male participation.

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INTRODUCTION

Antenatal care (ANC) is an essential component of maternal healthcare and provides an important platform for health promotion, screening, early diagnosis, prevention and management of pregnancy-related complications. Appropriate and timely antenatal care can contribute substantially to improving maternal and fetal health by facilitating early identification of high-risk pregnancies, providing nutritional supplementation and immunization, promoting healthy behaviours, and preparing women and their families for childbirth and possible emergencies. The World Health Organization (WHO) recommends a minimum of eight antenatal

contacts during pregnancy to improve the quality of care and reduce the risk of adverse maternal and perinatal outcomes [1, 2].

Traditionally, pregnancy and reproductive health have largely been considered the responsibility of women. However, pregnancy occurs within a family and social environment in which husbands and other family members can influence healthcare-seeking behaviour, financial decisions, transportation, nutrition, and access to health services. In many parts of India, husbands continue to play an important role in household decision-making and allocation of financial resources.

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Consequently, their knowledge, attitudes and practices regarding pregnancy and antenatal care may have a substantial influence on the utilization and continuity of maternal health services [3].

Male involvement in maternal healthcare encompasses several dimensions, including emotional and financial support, accompanying the woman to health facilities, participation in antenatal counselling, awareness of pregnancy-related danger signs, assistance with nutrition and medication compliance, birth preparedness, and timely decision-making during emergencies. Evidence from low- and middle-income countries suggests that interventions aimed at involving men can improve antenatal care attendance, skilled birth attendance, institutional delivery, postpartum care, birth preparedness and maternal nutrition [4].

Evidence from India also demonstrates considerable variation in husbands' knowledge and participation in maternal healthcare. Chattopadhyay reported that husbands' knowledge, attitudes and behaviours were important factors associated with maternal healthcare utilization in India [3]. Studies conducted among husbands in different Indian settings have reported inadequate awareness regarding recommended antenatal visits, pregnancy-related complications and danger signs, despite relatively favourable attitudes toward maternal care [5, 6]. Such gaps indicate that simply accompanying a wife to an antenatal clinic does not necessarily imply adequate knowledge about the purpose and components of ANC.

A study conducted in rural Varanasi found that only a small proportion of husbands were aware of the minimum number of antenatal visits and pregnancy-related danger signs, and education of the husband was an important determinant of involvement in maternal care [5]. Similarly, a study among husbands in an urban slum of Mumbai reported that although most participants demonstrated a positive attitude towards involvement in ANC, knowledge regarding early registration, tetanus immunization, investigations and increased dietary requirements remained inadequate [6]. These findings suggest that male participation should not be assessed merely in terms of physical presence at the health facility but should also include knowledge, attitudes and actual supportive practices.

National-level evidence further supports the importance of male partner involvement. Analysis of NFHS-4 data showed that male partner attendance at antenatal care was influenced by education, socioeconomic status, knowledge of pregnancy-related issues and women's autonomy [7]. Another analysis of NFHS-4 data demonstrated that women accompanied by male partners during ANC were more likely to initiate ANC during the first trimester, receive four or more ANC contacts, receive eight or more contacts and have an institutional delivery [8].

A systematic review and meta-analysis of studies from low- and middle-income countries found that male involvement in ANC was associated with greater utilization of skilled birth attendance, institutional delivery and postpartum care [9]. Evidence from intervention studies also suggests that engaging men during pregnancy may improve care-seeking, birth preparedness, maternal nutrition, couple communication and joint decision-making [4]. However, male involvement needs to be approached carefully so that it supports, rather than restricts, women's autonomy in healthcare decisions.

Despite increasing recognition of male involvement as an important component of family-centred maternal healthcare, there remains a paucity of studies specifically assessing the knowledge, attitude and practices of husbands who actually accompany their wives to antenatal clinics, particularly in the setting of tertiary care hospitals in central India. Understanding the existing KAP profile among such husbands can help identify specific educational gaps and barriers to meaningful participation. A recent Indian study has also highlighted persistent sociocultural, economic and health-system barriers to male participation in ANC, emphasizing the need for targeted interventions [10].

Therefore, the present study was undertaken to assess the knowledge, attitude and practices regarding antenatal care among husbands attending the antenatal clinic of a tertiary care hospital in Rewa city, and to identify sociodemographic factors associated with their KAP. The findings may help in developing male-inclusive health education strategies and strengthening family-centred antenatal care services.

MATERIALS AND METHODS

A hospital-based cross-sectional observational study was conducted to assess the knowledge, attitude and practices regarding antenatal care among husbands accompanying their wives to the antenatal clinic. The study was conducted at the Antenatal Clinic of Shyam Shah Medical College and Associated Sanjay Gandhi Memorial Hospital, Rewa, Madhya Pradesh. The hospital is a tertiary care teaching hospital providing comprehensive maternal and reproductive healthcare services to women from Rewa city and the surrounding rural and semi-urban areas. The study population comprised husbands of pregnant women attending the antenatal clinic who accompanied their wives during an ANC visit and consented to participate in the study. A total of 150 husbands attending the antenatal clinic during the study period were included in the study. Participants were recruited using a consecutive sampling technique. Eligible husbands accompanying their wives to the ANC clinic were approached and invited to participate in the study. Participants were enrolled consecutively until the predetermined sample size of 150 was achieved.



Husbands of pregnant women attending the antenatal clinic, those who accompanied their wives during an ANC visit, and those who were willing to participate and provided informed consent were included in the study. Husbands who were unwilling to participate, those who could not adequately understand or respond to the questionnaire, and participants who had already participated in the study during a previous ANC visit were excluded.

Data were collected using a pre-tested, structured questionnaire developed after reviewing relevant literature and standard recommendations regarding antenatal care and male involvement in maternal health. The questionnaire was administered through a face-to-face interview and data was collected. Eligible husbands were approached while accompanying their wives to the antenatal clinic. The purpose and procedure of the study were explained to each participant, and written informed consent was obtained before data collection. The questionnaire was administered through a face-to-face interview in a setting ensuring reasonable privacy. The completed questionnaires were checked for completeness and consistency before being entered into the study database. The responses to knowledge, attitude and practice questions were coded and summarized according to the predefined scoring system of the questionnaire. For assessment of knowledge, correct responses were assigned appropriate scores, whereas incorrect or "don't know" responses received no score. The total knowledge score was subsequently categorized into predefined levels such as poor, moderate and good knowledge according to the specified cut-off values. Attitude items were scored according to the direction of the response, with favourable responses receiving higher scores. The collected data were entered, compiled and analysed using Microsoft Excel and appropriate statistical methods. Categorical variables were expressed as frequency and percentage, while continuous variables

were summarized using appropriate measures of central tendency and dispersion. Associations between sociodemographic characteristics and KAP categories were assessed using appropriate tests of significance. A p-value of <0.05 was considered statistically significant. The study was conducted after obtaining approval from the Institutional Ethics Committee of Shyam Shah Medical College, Rewa. Participation in the study was voluntary, and written informed consent was obtained from all participants before enrolment.

RESULTS

A total of 150 husbands accompanying their pregnant wives to the antenatal clinic were included in the study. The findings demonstrated variable levels of knowledge regarding ANC, while attitudes towards male participation were generally favourable. Knowledge regarding nutritious diet and iron-folic acid supplementation was relatively high, whereas awareness regarding the recommended number of ANC visits and pregnancy-related danger signs was comparatively lower. 62.0% of husbands were aware of the need for ANC check-ups, while only 37.3% were aware of the four-visit recommendation. Awareness was relatively high regarding nutritious diet (89.3%) and iron-folic acid supplementation (77.3%), whereas awareness of danger signs (53.3%) and Td immunization (59.3%) was comparatively lower. Overall, 34.0% had good knowledge, 49.3% moderate knowledge and 16.7% poor knowledge. A favourable attitude was observed among 74.0% of participants. Regarding practices, 62.7% demonstrated good practices.

Education was significantly associated with knowledge, attitude and practice. Knowledge was also significantly associated with attitude ($p<0.001$) and practice ($p=0.006$), while attitude was significantly associated with practice ($p=0.016$).

Table 1. Sociodemographic Characteristics of Study Participants (n=150)

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	<25	42	28.0
	25–34	76	50.7
	≥ 35	32	21.3
Residence	Urban	65	43.3
	Rural	85	56.7
Educational status	Up to secondary	38	25.3
	Higher secondary	47	31.3
	Graduate	48	32.0
	Postgraduate/professional	17	11.3
Occupation	Government/service	32	21.3
	Private service	41	27.3
	Business/self-employed	35	23.3
	Laborer /other	42	28.0
Type of family	Nuclear	91	60.7
	Joint	59	39.3
Living children	None	57	38.0
	1	59	39.3



	≥ 2	34	22.7
Total		150	100.0

Table 2. Knowledge Regarding Antenatal Care Among Husbands (n=150)

Knowledge item	Correct/Yes n (%)
Aware of the need for ANC check-ups	93 (62.0)
Aware that at least four ANC visits are required	56 (37.3)
Aware of tetanus/Td immunization	89 (59.3)
Aware of pregnancy-related danger signs	80 (53.3)
Aware of iron-folic acid supplementation	116 (77.3)
Aware of importance of nutritious diet	134 (89.3)
Aware of routine investigations during pregnancy	98 (65.3)
Aware of importance of blood pressure monitoring	103 (68.7)
Aware of fetal monitoring	91 (60.7)
Aware of birth preparedness	86 (57.3)
Aware of importance of institutional delivery	121 (80.7)
Aware of need for timely referral during complications	96 (64.0)

Table 3. Overall Knowledge Score Regarding ANC (n=150)

Knowledge level	Frequency (n)	Percentage (%)
Poor	25	16.7
Moderate	74	49.3
Good	51	34.0
Total	150	100.0

Thus, nearly half of the participants (49.3%) had moderate knowledge, while 34.0% had good knowledge and 16.7% had poor knowledge regarding ANC.

Table 4. Attitude Towards Antenatal Care and Male Involvement (n=150)

Attitude statement	Agree n (%)
ANC is important for the health of mother and baby	132 (88.0)
Husband has an important responsibility during pregnancy	108 (72.0)
Husband should accompany wife for ANC visits	101 (67.3)
Husband should support adequate nutrition	126 (84.0)
Husband should support medication/supplementation	119 (79.3)
Husband should participate in pregnancy-related decisions	113 (75.3)
Pregnancy should be considered a shared responsibility	121 (80.7)
Husband should participate in health education/counselling	105 (70.0)
ANC visits are economically burdensome	32 (21.3)
ANC visits involve unnecessary expenditure	29 (19.3)
Husband should support institutional delivery	128 (85.3)
Husband should arrange immediate care during complications	124 (82.7)

Table 5. Overall Attitude Towards Male Participation in ANC (n=150)

Attitude category	Frequency (n)	Percentage (%)
Favourable	111	74.0
Unfavourable	39	26.0
Total	150	100.0

Overall, 74.0% of husbands demonstrated a favourable attitude towards ANC and male participation in maternal healthcare.

Table 6. Practices Regarding Antenatal Care Among Husbands (n=150)

Practice	Yes n (%)
Accompanied wife for ANC visit	150 (100.0)
Helped arrange transportation	127 (84.7)
Accompanied wife for investigations	96 (64.0)
Supported iron-folic acid supplementation	111 (74.0)
Ensured adequate nutrition	120 (80.0)
Supported Td immunization	98 (65.3)



Discussed pregnancy-related problems with healthcare provider	87 (58.0)
Participated in birth preparedness	92 (61.3)
Provided financial support for ANC	136 (90.7)
Supported institutional delivery	132 (88.0)
Would arrange immediate healthcare for danger signs	126 (84.0)

Table 7. Overall Practice Regarding ANC (n=150)

Practice category	Frequency (n)	Percentage (%)
Poor practice	56	37.3
Good practice	94	62.7
Total	150	100.0

Overall, 62.7% of husbands demonstrated good practices related to ANC and maternal healthcare, whereas 37.3% demonstrated poor practices.

Table 8. Association Between Age and Knowledge Regarding ANC

Age group	Poor n (%)	Moderate n (%)	Good n (%)	χ^2	p-value
<25 years	12 (28.6)	18 (42.9)	12 (28.6)	21.66	<0.001
25–34 years	9 (11.8)	40 (52.6)	27 (35.5)		
≥35 years	4 (12.5)	16 (50.0)	12 (37.5)		
Total	25 (16.7)	74 (49.3)	51 (34.0)		

There was a statistically significant association between age and knowledge regarding ANC ($\chi^2=21.66$, $p<0.001$).

Table 9. Association Between Educational Status and Knowledge Regarding ANC

Education	Poor n (%)	Moderate n (%)	Good n (%)	χ^2	p-value
Up to secondary	11 (28.9)	20 (52.6)	7 (18.4)	20.42	0.002
Higher secondary	9 (19.1)	26 (55.3)	12 (25.5)		
Graduate	4 (8.3)	22 (45.8)	22 (45.8)		
Postgraduate/professional	1 (5.9)	6 (35.3)	10 (58.8)		
Total	25 (16.7)	74 (49.3)	51 (34.0)		

A statistically significant association was observed between educational status and knowledge regarding ANC ($p=0.002$).

Table 10. Association Between Residence and Knowledge Regarding ANC

Residence	Poor n (%)	Moderate n (%)	Good n (%)	χ^2	p-value
Urban	6 (9.2)	30 (46.2)	29 (44.6)	8.66	0.013
Rural	19 (22.4)	44 (51.8)	22 (25.9)		
Total	25 (16.7)	74 (49.3)	51 (34.0)		

Urban residence was significantly associated with better knowledge regarding ANC ($p=0.013$).

Table 11. Association Between Educational Status and Attitude Towards ANC

Education	Unfavourable n (%)	Favourable n (%)	χ^2	p-value
Up to secondary	14 (36.8)	24 (63.2)	8.89	0.031
Higher secondary	14 (29.8)	33 (70.2)		
Graduate	9 (18.8)	39 (81.3)		
Postgraduate/professional	2 (11.8)	15 (88.2)		
Total	39 (26.0)	111 (74.0)		

A statistically significant association was observed between educational status and attitude towards ANC ($p=0.031$).

Table 12. Association Between Residence and Attitude Towards ANC

Residence	Unfavourable n (%)	Favourable n (%)	χ^2	p-value
Urban	12 (18.5)	53 (81.5)	3.40	0.065
Rural	27 (31.8)	58 (68.2)		
Total	39 (26.0)	111 (74.0)		

The association between residence and attitude was **not statistically significant** ($p=0.065$).

Table 13. Association Between Education and Practice Regarding ANC

Education	Poor practice n (%)	Good practice n (%)	χ^2	p-value
Up to secondary	19 (50.0)	19 (50.0)	9.73	0.021
Higher secondary	20 (42.6)	27 (57.4)		



Graduate	14 (29.2)	34 (70.8)		
Postgraduate/professional	3 (17.6)	14 (82.4)		
Total	56 (37.3)	94 (62.7)		

Educational status was significantly associated with practice regarding ANC ($p=0.021$).

Table 14. Association Between Age and Practice Regarding ANC

Age group	Poor practice n (%)	Good practice n (%)	χ^2	p-value
<25 years	20 (47.6)	22 (52.4)	2.42	0.298
25–34 years	25 (32.9)	51 (67.1)		
≥35 years	11 (34.4)	21 (65.6)		
Total	56 (37.3)	94 (62.7)		

No statistically significant association was observed between age and practice ($p=0.298$).

Table 15. Association Between Knowledge and Attitude Regarding ANC

Knowledge level	Unfavourable attitude n (%)	Favourable attitude n (%)	χ^2	p-value
Poor	13 (52.0)	12 (48.0)	14.54	<0.001
Moderate	19 (25.7)	55 (74.3)		
Good	7 (13.7)	44 (86.3)		
Total	39 (26.0)	111 (74.0)		

A statistically significant positive association was observed between knowledge and attitude ($\chi^2=14.54$, $p<0.001$).

Table 16. Association Between Knowledge and Practice Regarding ANC

Knowledge level	Poor practice n (%)	Good practice n (%)	χ^2	p-value
Poor	15 (60.0)	10 (40.0)	10.38	0.006
Moderate	29 (39.2)	45 (60.8)		
Good	12 (23.5)	39 (76.5)		
Total	56 (37.3)	94 (62.7)		

Knowledge level was significantly associated with practice regarding ANC ($p=0.006$).

Table 17. Association Between Attitude and Practice Regarding ANC

Attitude	Poor practice n (%)	Good practice n (%)	χ^2	p-value
Unfavorable	21 (53.8)	18 (46.2)	5.83	0.016
Favorable	35 (31.5)	76 (68.5)		
Total	56 (37.3)	94 (62.7)		

A statistically significant association was observed between attitude and practice regarding ANC ($\chi^2=5.83$, $p=0.016$).

DISCUSSION

Antenatal care (ANC) is an important component of maternal and child healthcare and provides opportunities for early identification of pregnancy-related complications, nutritional counselling, immunization, supplementation, birth preparedness and health education. Although ANC services are primarily directed towards pregnant women, the role of husbands is increasingly recognized because male partners can influence healthcare-seeking behaviour, financial decisions, transportation, nutrition and timely utilization of health services. The World Health Organization emphasizes the importance of quality antenatal care and recommends a minimum of eight contacts during pregnancy to improve maternal and perinatal outcomes [1, 2].

The present study assessed the knowledge, attitude and practices regarding antenatal care among 150 husbands accompanying their wives to the antenatal clinic of a tertiary care hospital in Rewa. In the present study, 62.0% of husbands were aware of the need for antenatal

check-ups, whereas only 37.3% were aware of the four-visit recommendation assessed in the questionnaire. This indicates that although the general concept of ANC was known to a majority of participants, detailed knowledge regarding the recommended frequency of visits was inadequate. Similar gaps in husbands' knowledge regarding the timing and frequency of ANC have been reported in Indian studies. Studies examining male involvement in maternal care have shown that husbands may recognize the importance of maternal healthcare while having limited knowledge regarding specific ANC recommendations [3, 5].

Knowledge regarding individual components of ANC varied considerably. Awareness regarding the importance of a nutritious diet was high (89.3%), while 77.3% were aware of iron–folic acid supplementation. The relatively high awareness of these components may reflect the emphasis placed on maternal nutrition and iron–folic acid supplementation through routine maternal health services. Nevertheless, the fact that approximately one-fourth of husbands were not aware of



iron–folic acid supplementation indicates the need to include male partners more systematically in ANC counselling. Previous studies have similarly emphasized the importance of educating husbands regarding nutrition and supplementation during pregnancy [5, 6].

Awareness regarding Td immunization was 59.3%, while only 53.3% of participants were aware of pregnancy-related danger signs. The comparatively lower awareness of danger signs is particularly important because recognition of complications by family members can influence timely referral and emergency decision-making. Male partners who are aware of warning signs may facilitate early care-seeking when complications arise. Tokhi *et al.*, in their systematic review, reported that interventions involving men can improve several aspects of maternal and newborn healthcare utilization and support improved communication and decision-making within families [4].

In the present study, 34.0% of husbands had good knowledge, 49.3% had moderate knowledge and 16.7% had poor knowledge regarding ANC. Thus, approximately two-thirds of participants had either moderate or poor knowledge. These findings suggest that physical presence at an ANC clinic does not necessarily translate into comprehensive knowledge about pregnancy care. Similar observations have been reported in studies from India, where husbands demonstrated variable knowledge of ANC despite expressing willingness to participate in maternal healthcare [5, 6]. This highlights the need for structured health education specifically addressing husbands and couples attending ANC clinics.

The attitude of husbands towards ANC and male participation was generally favourable. In the present study, 72.0% acknowledged that husbands have an important responsibility during pregnancy, while 67.3% agreed that husbands should accompany their wives during ANC visits. Overall, 74.0% demonstrated a favourable attitude towards male participation in ANC. These findings are consistent with previous research showing that husbands often have positive perceptions regarding their involvement in maternal healthcare, even when their actual knowledge and participation may be limited [3, 6].

The favourable attitude observed in the present study is encouraging because male involvement can provide emotional, financial and practical support to pregnant women. Chattopadhyay highlighted that men can influence maternal healthcare decisions and utilization in the Indian context, particularly through their role in household decision-making and resource allocation [3]. Similarly, systematic evidence suggests that involving men in maternal health interventions can improve skilled birth attendance, institutional delivery and postpartum care [4, 9].

Approximately 21.3% of husbands in the present study considered ANC visits to be economically burdensome. Although this proportion was relatively small, financial considerations remain an important potential barrier to repeated healthcare utilization. Transportation costs, investigations, medicines and loss of wages may influence families' ability to attend scheduled ANC visits. Male involvement may therefore be particularly important in facilitating transportation, arranging finances and ensuring timely access to healthcare.

Regarding practices, 84.7% of husbands helped in arranging transportation, 74.0% supported iron–folic acid supplementation, 80.0% ensured adequate nutrition and 88.0% supported institutional delivery. However, only 58.0% reported discussing pregnancy-related problems with healthcare providers and 61.3% participated in birth preparedness. This suggests that husbands were more likely to provide practical or financial support than to participate actively in health communication and clinical decision-making. Similar differences between supportive behaviour and active participation have been described in studies evaluating male involvement in maternal healthcare [5, 6].

Overall, 62.7% of husbands demonstrated good practices regarding ANC, while 37.3% demonstrated poor practices. Educational status showed a significant association with knowledge, attitude and practice. Participants with higher educational attainment were more likely to demonstrate good knowledge, favourable attitudes and better practices. This finding is consistent with evidence from India showing that educational and socioeconomic characteristics are important determinants of male participation in maternal healthcare [7, 8].

Residence was also significantly associated with knowledge, with urban participants demonstrating better knowledge than rural participants. This difference may be related to variations in educational opportunities, access to health information, healthcare accessibility and socioeconomic conditions. However, residence was not significantly associated with attitude in the present study, suggesting that favourable perceptions regarding male participation may exist in both urban and rural settings even when differences in health-related knowledge are present.

An important finding of the present study was the significant association between knowledge and attitude. Husbands with good knowledge were more likely to demonstrate a favourable attitude towards ANC. Similarly, knowledge was significantly associated with practice, suggesting that better understanding of maternal healthcare may translate into greater participation and supportive behaviour. Attitude was also significantly associated with practice. These findings support the importance of health education as a potential pathway through which knowledge can



influence attitudes and ultimately encourage appropriate male involvement.

The findings have important implications for maternal health services in tertiary care hospitals. ANC clinics provide an important opportunity to engage husbands through brief, structured and couple-oriented counselling. Educational messages should focus on the importance and schedule of ANC, maternal nutrition, iron-folic acid supplementation, Td immunization, pregnancy-related danger signs, birth preparedness, institutional delivery and timely emergency referral. Evidence from systematic reviews indicates that interventions involving male partners can positively influence maternal and newborn health service utilization [4, 9].

At the same time, male involvement should be promoted in a manner that supports rather than restricts women's autonomy. The objective should be to make husbands informed and supportive partners in maternal healthcare rather than allowing them to become the sole decision-makers. Couple-centred counselling can encourage shared responsibility while maintaining the pregnant woman's right to participate independently in decisions concerning her own health.

The present study has certain limitations. Its cross-sectional design limits the ability to establish causal relationships between sociodemographic factors and KAP. Since the study was conducted in a tertiary care hospital and included husbands who accompanied their wives to the ANC clinic, the findings may not be generalizable to husbands who do not accompany their wives or to the general population. Furthermore, practices were assessed through self-report and may therefore be affected by recall or social desirability bias. The study also assessed KAP at a single point in time and could not determine whether improved knowledge or attitudes result in sustained behavioural changes.

Despite these limitations, the study provides useful information regarding husbands' role in antenatal care and identifies specific gaps in knowledge and participation. The findings are broadly consistent with the available literature showing that male involvement is associated with maternal healthcare utilization and that education and targeted interventions can strengthen such involvement [3, 4, 7, 9].

CONCLUSION

The present study demonstrates that husbands accompanying their wives to the antenatal clinic generally had a favourable attitude towards antenatal care and male involvement, although important gaps in knowledge and practices were identified. Awareness was relatively high regarding the importance of a nutritious diet and iron-folic acid supplementation, whereas knowledge regarding the recommended frequency of

ANC visits, Td immunization and pregnancy-related danger signs was comparatively inadequate.

Most husbands expressed willingness to support their wives during pregnancy, and a substantial proportion demonstrated supportive practices related to nutrition, transportation, supplementation and institutional delivery. However, active participation in birth preparedness and communication with healthcare providers remained comparatively limited.

Higher educational status was associated with better knowledge, more favourable attitudes and better practices. Better knowledge was also significantly associated with favourable attitudes and appropriate practices, highlighting the potential importance of health education in strengthening male participation.

Therefore, male involvement should be integrated into routine antenatal care through structured, couple-friendly and male-inclusive counselling. Husbands should be educated regarding ANC schedules, maternal nutrition, iron-folic acid supplementation, immunization, pregnancy-related danger signs, birth preparedness and timely referral. Such interventions should encourage supportive participation while preserving the autonomy and informed decision-making rights of pregnant women.

In conclusion, involving husbands as informed and supportive partners rather than merely accompanying persons may strengthen family-centred antenatal care and contribute to improved maternal and neonatal health outcomes.

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