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Assessing the Status and Barriers to Male Involvement in Maternal Health Care Services in Kigamboni District, Tanzania

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Abstract

Male involvement in maternal health care is an effective approach to improving maternal and child health. Despite this, it has been perceived as a woman's responsibility and is a significant challenge in developed and developing countries, including Tanzania. Furthermore, evidence is scarce regarding male involvement in maternal health care in some parts of the country, including Kigamboni District. Therefore, by employing the Socio-Ecological Model (SEM), this study assesses the current status of male involvement in maternal health care. The descriptive nature study allowed for the collection of quantitative and qualitative information. A sample size of 100 men was selected to participate in the survey. Two FGDs and four KIIs were also conducted. Descriptive analysis was performed for quantitative data, while thematic content analysis was done for qualitative data. Findings for this study revealed that some 34%, 43% and 23% of men accompanied their partners to antennal care, for delivery, and to postnatal care, respectively. Some socio-economic backgrounds, such as education, occupation and age of respondents, contributed to male involvement in maternal health care. Similarly, disenabling factors such as attitudes of service providers, prohibitive social and cultural norms, economic factors, and health-related factors came out as key barriers to male active involvement in maternal health care. To enhance male involvement, the study recommends targeted educational campaigns, proactive engagement by healthcare providers, and community-based interventions aimed at reshaping gender norms and promoting positive male attitudes. Such efforts are essential for improving maternal and child health outcomes in Kigamboni and across Tanzania

Keywords: Male involvement, Maternal Health Care Services, Barriers, Kigamboni, Tanzania.

1. Introduction

Male involvement in maternal health care is recognized as a critical strategy for improving maternal health outcomes (Maluka et al., 2020). In many cultures, maternal and child health (MCH) is perceived as primarily the responsibility of women, which can limit male partner involvement in crucial aspects of maternal health care. Evidence shows that male involvement in antenatal care, delivery, and postnatal care benefits women, families, the community and the healthcare system (Sakala et al., 2021). The need to include men in maternal health care resulted from the International Conference on Population Development (ICPD) held in Cairo, Egypt, in 1994. The conference urged special efforts to emphasize men's shared responsibility and promote active involvement in responsible parenthood, sexual and

reproductive behaviour, family planning, and prenatal, maternal and child health (Sakala et al., 2021; United Nations, 1995). Consequently, the 1995 World Conference on Women held in Beijing marked the significant recognition that women's empowerment requires men's engagement to advance improvement in reproductive, maternal, newborn and child health (RMNCH) outcomes (UNFPA, 2019). The ICPD conference and the 1995 World Conference on Women in Beijing marked the significant recognition that women's empowerment requires men's engagement to advance positive improvements in RMNCH. The Beijing Declaration noted a broad consensus to "encourage men to participate fully in all actions toward equality" (UNFPA, 2019). This intersectional approach demands meaningful male involvement to uncover and address male attitudes, beliefs and practices that sustain gendered power differentials and reinforce inequalities between women and men.

Before the global conferences, reproductive health programs were focused on women's health, viewing men as non-actors whose role was irrelevant (United Nations, 1995). Thus, UNFPA (2019) contended that men have the potential to act as allies, partners, and co-beneficiaries in women's empowerment by recognizing that restricted gender norms affect both men and women. Furthermore, men play a crucial role in the general health of the family as men's understanding of reproductive, maternal, newborn and child health (MNCH) affects women's access to and uptake of reproductive, maternal, newborn and child health (RMNCH) services, utilization and outcomes (Yargawa & Leonard, 2015).

Globally, male partners have a great role in decision-making on health at the family level (Sharma et al., 2019). There has been increasing attention on the role of male involvement in women's reproductive health after recognizing that men's attitudes, knowledge, and behaviours can strongly influence women's health choices, their well-being as mothers and newborns (Singh et al., 2014). Utilization of family planning has also been reported to improve when men are included in the counselling process with their spouse (Alio et al., 2013). Moreover, other studies have shown that male involvement results in increased access to postpartum services (Redshaw, 2015), reduced maternal smoking and depression, and reduced risks of infant mortality (Alio et al., 2013). Thus, the concept of male involvement in reproductive health has been advocated as an essential element of the World Health Organization (WHO) initiative for making pregnancy safer (WHO, 2018). It was important to ensure that special efforts should be taken to emphasize men's shared responsibility and promote their active involvement in parenthood and sexual and reproductive behaviour, including family planning; prenatal, natal, postnatal, and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution of family income, children's education, health and nutrition; recognition and promotion of equal value of children of both sexes.

Despite the positive contributions, in many Sub-Saharan African countries, maternal health care remains largely perceived as a women's domain, and male participation is low (Muheirwe and Nuhu, 2019). A study conducted in Southern Africa showed a low prevalence of 14%, while another study in Ghana revealed a low % male involvement of 35% (Craymah et al., 2017). In East Africa, a national survey in Kenya reported a 35% male involvement in maternal health care, while a study in Uganda indicated a much lower involvement of 6%, as reported by Nyamai et al., 2022; Odeny et al., 2019; Kairuki et al., 2016 respectively. In Tanzania, the (Tanzania Demographic Health Survey and Malaria Indicator Survey (TDHS-MIS) shows that less than 30% of male partners accompany their spouses for maternal health (TDHS-MIS, 2015-16; Kabanga et al., 2019). Some studies have explored the reasons related to low male involvement and have cited socio-cultural norms viewing pregnancy as a private women's issue and lack of awareness about the importance and benefits of involvement as among the reasons. Long

distances to health facilities and the inability to take time off from work were also reasons, as cited by Gibore and Bali, 2020). However, there is limited documentation on the status of male involvement and its associated factors in maternal health care in specific contexts such as Kigamboni District. While male involvement in reproductive health and specific maternal health care benefits is generally well established (UNFPA, 2019; WHO, 2007), the particular status in the local context has not been thoroughly explored. Therefore, this study assessed the status and barriers to male participation in maternal health care and explored male partners' perspectives on their involvement at maternal health facilities with their partners during pregnancy, prenatal and postnatal in Kigamboni District. The findings from this study inform the design of intervention strategies towards improving male involvement in MCH services at the local, national and international arenas.

2. Literature Review

The literature review on the status and barriers of male involvement in antenatal clinics is provided below. It begins with a general overview of male participation in maternal health, followed by the theoretical framework guiding the study, and finally gives a road map of variables under this study as stipulated in the conceptual framework.

2.1 Overview of male involvement in maternal health care

Male involvement or participation in maternal health care is defined as men attending antenatal clinics with their partners, knowing their partner's antenatal appointment, discussing antenatal interventions with their partners, supporting their partner's antenatal visits financially, and taking time to find out what is going on in the antenatal clinic during the current pregnancy (Byamugisha et al., 2010). However, in most cultures, family planning, pregnancy and childbirth are regarded as exclusively women's affairs. Generally, most men do not accompany their wives to family planning, antenatal care and postnatal service and are even not expected to attend the birth of their children. A 2010 study in Nepal reported a low rate of men accompanying their partners for antenatal care and their children's immunization. A similar study revealed that most men's involvement in their partner's pregnancy revolved around helping them with domestic work and financial support and providing means of transport to antenatal clinics and during delivery. According to this study, most men viewed maternal health as a woman's duty (Bhatta, 2013). Several studies in Sub-Saharan Africa have reported low male participation rates in antenatal care services. A study conducted in Kwazulu Natal State, South Africa, found that both men and women were positive about involving men with their partners in maternity health. However, there was no guarantee of their participation in consultation and discussion forums as most just sat outside waiting for their partners to attend to them and escort them home (Mullick et al., 2005). A similar study by Byanmugisha et al. (2010) in Uganda reported that 26% of men whose wives attended antenatal care at Mbale Regional Referral Hospital reported full male involvement in MCH. In Nigeria, qualitative interviews revealed that many men were absent at antenatal appointments (Sharma et al., 2019). In a study by Kabanga et al. (2019) in Kyela, Tanzania, the prevalence of men attending MCH visits with their partners was 56.9%. This prevalence is higher than that reported in other studies done in Mbeya (Msuya et al., 2008). In another study in northern Tanzania, Elias et al. (2017) reported that few men attended the MCH-voluntary and counselling services during prenatal compared to those post-postnatal. The reviewed studies, such as those of Kabanga et al. (2019), Byanmugisha et al. (2010), Sharma et al. (2019), and Elias et al. (2017), have been conducted in some regions of Tanzania and other parts of Sub-Saharan Africa to assess the prevalence of male participation in antenatal care services. These studies

provide valuable insights into male involvement in antenatal care in various African contexts; however, there is a lack of research specifically focused on the Kigamboni district of Tanzania. This study addressed this research gap in assessing male involvement status and barriers in a specific context such as the Kigamboni district.

2.2 Conceptual Framework

This study is guided by the **Socio-Ecological Model (SEM)**, which provides a comprehensive framework for understanding the multifaceted and interrelated factors influencing male involvement in maternal health care. Several models have been used to study health-related matters (Tesfay et al., 2021); however, SEM has not been used to understand male involvement in maternal health care. The current study used the SEM proposed by Urie Bronfenbrenner (Brenner, 1979) to assess the status and barriers to male involvement in maternal health. The SEM framework (Figure 1) recognizes that individual behaviour is influenced by multiple levels of factors: individual, interpersonal, community, institutional, and policy. At the individual level, it focuses on individual characteristics such as knowledge, attitudes, beliefs, personal behaviours, and decision-making processes. At the interpersonal level, factors such as relationships with others, such as family members, friends, and peers, as well as social networks and support, are included. The community-level factors include the cultural, social, and physical environments in which individuals live, including expectations and norms within the community. The last level is the institutional level, which includes larger societal and cultural influences such as laws, policies, and organizational systems that shape personal behaviour. The SEM recognizes that these different levels of influence interact and can cumulatively impact male involvement in maternal health care. By employing the SEM, this study explored factors influencing male involvement in maternal health care in peri-urban communities like Kigamboni District. Understanding these multi-level influences will inform the development of targeted interventions to enhance male participation and improve maternal and child health outcomes.

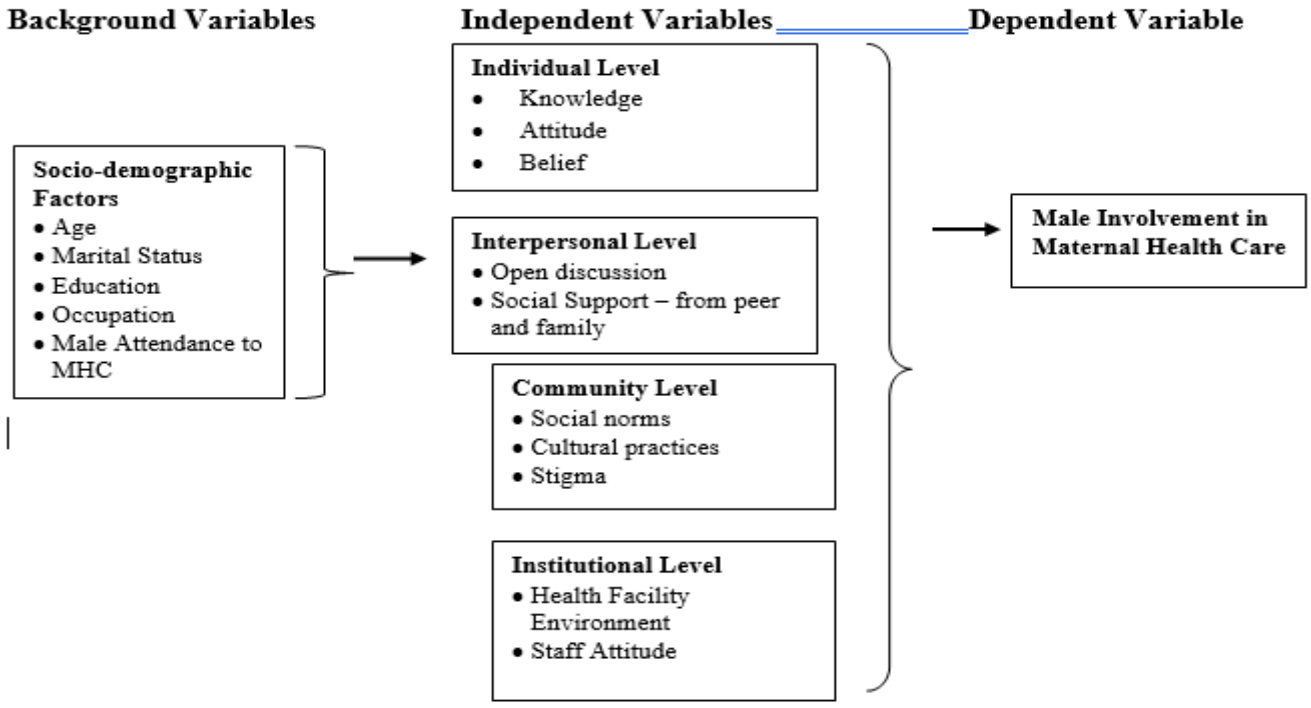

Figure 1: Conceptual Framework on barriers to male involvement in antenatal care.
Adapted from Urie Bronfenbrenner (Brenner, 1979).

3. Research Methodology

Section three describes how the research was conducted. It gives details of the study design, targeted population, sample size and sampling procedure, methods for data collection, collections tools and the process for data analysis.

3.1 Description of study area

The study was carried out at Kigamboni District Council. Kigamboni district combines urban and peri-urban populations, making it a useful case for understanding diverse perspectives of male involvement. While previous studies such as Kabanga et al. (2019), Byanmugisha et al. (2010), Sharma et al. (2019), and Elias et al. (2017) have been conducted in rural or pure urban areas, few have focused on peri-urban district like Kigamboni, where both traditional and modern influences shape health-seeking behaviour. This transitional setting provides a unique opportunity to see how urbanization and changing lifestyles influence health-seeking behaviours and male involvement in antenatal care.

3.2 Research design

The study used a cross-sectional research design. To achieve its objectives, a mixed methods research approach was used, which was descriptive in nature. The study population consisted of men between 18-60 years with a partner who was pregnant at the time of study or who had a child of two years. Both quantitative and qualitative data were collected. Quantitative data was collected through structured questionnaires administered to men. Similarly, to collect qualitative data, two Focus Group Discussions (FGDs) consisting of men were conducted in two sites to get a wider perspective of male involvement in antenatal care. In addition, Key Informant Interviews (KIIs) involved the healthcare worker in charge of antenatal care at the two selected clinics and the Ward Health Officer (WHO) for the Kigamboni ward involved.

3.3 Sample size and sampling procedure

Using Kish Leslie's formula, n = (z^2 p(100-p))/ε^2 by assuming that the proportion of male involvement in maternal healthcare in Tanzania (p) was 40% (Mapunda et al., 2020) at a maximum error (ε) of 5%, z value at 95% level of confidence of 1.96 and 10% non-response rate, the minimum required sample size was 413. Since the study was conducted in Dar es Salaam, covering only one district, the sample size was revised to 100 respondents. The revised sample size, reflecting the study's actual data collection process, was adjusted to 100 respondents selected from four wards: Kibada, Maweni, Mjimwema and Kigamboni, to balance practical feasibility and representativeness. Despite being smaller than ideal, the sample size allows for valuable insights into understanding the status and benefits of male involvement in antenatal care.

3.4 Methods of data collection

Both quantitative and qualitative data were collected. Quantitative data were obtained by a structured questionnaire administered to male respondents. This method collected data on socio-demographics, levels of men's involvement in antenatal care, level of men's understanding of the benefits of antenatal care, and the level to which cultural, economic and health-related facilities-based barriers affect men's involvement in antenatal care. The FGDs comprised 8-12 participants drawn from two study sites randomly selected from the four study sites. In addition, (KIIs) that involved healthcare providers in charge of maternal care were conducted at the four selected clinics.

3.5 Data analysis

The quantitative results obtained from the questionnaire were examined using descriptive statistics to ascertain the prevalence of insights concerning male involvement in antenatal care. Statistical Package

for Social Sciences (SPSS) software was employed to compute frequencies, percentages, and summarizing overarching trends within the dataset. The qualitative data from the FGDs and KIIs were transcribed and then examined thematically to identify recurring themes and patterns associated with study objectives.

3.6 Ethical considerations

Permission to conduct this study was requested from respective authorities. The researcher sought permission from the District Executive Director (DED) officer and was networked with community and ward health officers in particular wards of Kigamboni district. All participants provided informed consent before data collection, including comprehensive explanations of the study's objectives, methodologies, potential risks, and advantages. No names were used to ensure confidentiality. Respondents had the option of declining to participate in the study.

4. Findings and discussions

The findings of the study are discussed in this section. It presents the analysis of the views and opinions of the respondents about the status of male involvement in maternal health care in Kigamboni District, Tanzania. It entails the background information of the respondents, the prevalence of male participation in maternal health care, the knowledge and awareness of male partners concerning antenatal care and the influence of male partners' involvement in antenatal care.

4.1 Socio-demographic background of respondents

The results of participants' socio-demographic information are summarized in Table 1. Based on the findings, half of respondents were aged between 25 and 34, followed by 25% aged 18-24. Respondents aged 35 years and above were 15%, and the remaining 10% were in the age category of 50 and above. These findings imply that most respondents involved in the study were of appropriate reproductive age. It enables the researcher to get information on male involvement in antenatal care. Although male participation in antenatal care can vary based on age, some studies indicate no significant association between male partner age and attendance at antenatal care and that age may not be a strong predictor of involvement. Regarding educational attainment, four levels of education were recorded, with most respondents attending up to the primary level, which stood at 40%. Among respondents, 26% had secondary education, and 14% attended higher education (universities and colleges). Only 20% of respondents had never attended any formal education. The occupation of the respondents was measured in three categories, namely: government-employed (32%), privately employed (44%), and self-employed (24%). The government employed were those who were permanently engaged in a formal career as civil servants, whereas private employed were those who worked for others permanently or temporarily. The self-employed ones fall under those who were running their business either in the marketplaces, running a small shop or (motorcycle) bodaboda drivers. These three occupations impact male involvement in maternal health, especially when taking time off from work (through securing permissions) or leaving your job, like not opening a shop or not riding your bodaboda to take your partner to the clinic.

Table 1: Socio-demographic background of respondents (n = 100)

Variable	n	%
Age of the respondents		
18-24	25	25.0
25-34	50	50.0

35-49	15	15.0
50+	10	10.0
Education		
No formal education	20	20.0
Primary education	40	40.0
Secondary education	26	26.0
Higher education	14	14.0
Marital status		
Single	32	32.0
Married/Cohabitating	60	60.0
Divorced/Separated/Widowed	8	8.0
Occupation		
Government Employed	32	32.0
Private Employed	44	44.0
Self Employed	24	24.0

Source: Research, (2024).

4.2 Prevalence of male involvement in maternal health care

The male involvement in maternal health care results show that 45% reported attending a maternal health care clinic, while 55% did not participate. About 34% accompanied their partners to antenatal care, 43% to delivery, and 23% to postnatal (Fig. 1). There was a consensus in the FDGs where participants reported that they got involved in their spouses' antenatal clinics by accompanying them to clinics. A quote from the respondent in FGD Mjimwema:

"…When my wife was pregnant, I accompanied her to the clinic four times until she delivered. After she got a baby, I never went there…" (FGD, 2024).

The participants from FGD agreed that pregnancy is a critical phase in a woman's life, and it is therefore important to them as male partners to accompany them to the maternal health care clinics to make sure that they are okay, as for them pregnancy is like any other disease which needs support. The level of male participation observed in this study is much lower than what was reported in similar kind of studies in Tanzania by Gibore and Bali (2020), which was (59.3%), Mweya and Kazimili (2023) in Mbeya (44%) and Abie et al. (2023) in Ethiopia with the figure of 54.7%. The lower status of male involvement in maternal health care in Kigamboni may be attributed to several factors, including differences in geographic location or socio-economic conditions. Being a peri-urban place, Kigambini is characterized by diverse economic activities and cultural norms, which may shape male behaviours concerning maternal health care.

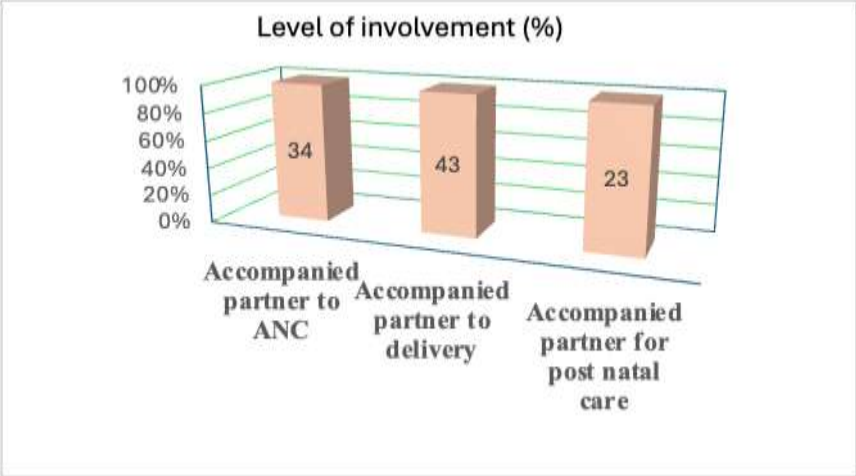

Figure 2: level of male involvement in maternal health care

Despite low involvement in maternal health care, their participation can be quite significant. When partners are involved, it increases their knowledge and awareness about pregnancy, childbirth, and infant care. It encourages a shared responsibility between the partners for the care of the infant. Moreover, the emotional support provided by the male partner during these appointments can help reduce the stress and anxiety levels of the pregnant woman, which can have a positive impact on the development and well-being of the infant. As one expectant father noted,

"…Being present at the antenatal appointments allowed me to understand better the changes my partner was going through and how I could support her during this important time…" (FGD: Kibada, 2024).

Another participant had this to share:

"…Participating in the antenatal classes with my wife made me feel more prepared and confident in my role as a father-to-be…" (FGD: Mji Mwema, 2024).

The study also found that most respondents reported that lack of knowledge about maternal health care was the main reason for their low involvement (34%). The other reasons were separation, especially for couples not living together (24%), and being too busy to attend antenatal care clinics. Although not mentioned by many respondents, the fear of being tested for HIV/AIDS was cited as a reason for a few men (20%) not to attend antenatal care. One of the routine services given at the health facility during the first antenatal visit is HIV testing. This idea stems from earlier Prevention of Mother to Child Transmission of HIV (PMTCT) campaigns that argued men should be tested for HIV at health facilities. Thus, the majority of male partners do not like to test for HIV. To them, HIV testing is petitioning more problems in their relationship. In KII, the ward health officer of Gezaulole revealed that:

"…men are afraid of knowing their HIV status. They do not accompany their partners due to fear of testing for HIV. For them, testing for HIV is to welcome more problems in their relationship. They believed that the status of their partners is enough to conclude on their health status…" (KII: Kibada, 2024).

Table 2: Prevalence of male attendance in antenatal care

Variable	**n**	**%**
Have you ever attended an antenatal care clinic?		
Yes	45	45.0

No	55	55.0
Have you ever accompanied your partner to the MHC clinic?		
Yes	46	46.0
No	54	54.0
How many times did you attend the monthly clinic screening		
Not all	24	24.0
Once	30	30.0
Twice	20	20.0
Three times	16	16.0
Four and more than 4 times	10	10.0
What are the reasons for not accompanying your partner		
Busy with my work	22	22.0
Separation/no staying together	24	24.0
Lack of necessary information about antenatal care	34	34.0
Fear of testing for diseases such as HVI/AIDS	20	20.0

Source: Research, (2024)

This finding coincides with what is portrayed in the social-ecological framework, which states that, at the individual level, factors such as knowledge, attitude, and belief influence male involvement in MHC. Personal fear of HIV testing, which is mandatory for men during antenatal visits, may discourage their participation. Men in Tanzania may be less likely to attend clinics due to a combination of factors, including fear of disclosure, social expectations, and perceived stigma. A study by (Mandawa and Matiti, 2022) argued that the fear and social stigma attached to HIV caused men to prefer to attend clinics located further from their homes to avoid being recognized, even though this can increase travel costs and time. Thus, this study advocates for programs and education to address fear stigma and build confidentiality through targeted interventions to improve male partners' willingness to participate in HIV testing during antenatal care.

4.3 Barrier to male involvement in antenatal care

The discussion on barriers to male involvement in maternal health care is guided by the variables explained in adapted Socio-Ecological Model (SEM). In FGDs, few respondents reported health facility-related barriers, including an uncomfortable clinic environment, poor staff attitudes, and long waiting queues, as contributors to the lack of male involvement in antenatal care. The results are discussed based on themes in the socio-ecological model, which explain barriers to male involvement in maternal health care.

4.3.1 Social norms and cultural practices

Social norms and cultural practices of certain communities can have a significant impact on male involvement in maternal health care. Men who decide to take an active part in maternal health care may face negative stereotypes, which may discourage them from being involved in maternal health care. Few male partners acknowledged the importance of their involvement during antenatal care and childbirth. They expressed a desire to move away from traditional ways of not involving in maternal health care and take greater responsibility in supporting their spouses from early pregnancy through to delivery.

However, they also noted that societal pressures often discouraged their participation. These participants acknowledged that:

"… our African cultural values and norms are letting us down for thinking that reproductive health is for women, and men should not be involved…" (FGD: Kigamboni, 2024).

Another respondent revealed that:

"…according to our culture, especially in coastal areas like Kigamboni, a mother usually takes care of the children, not the father. The husband will only give support if his wife or a child is in critical condition. That is why when a man takes a child to the hospital, people ask, 'Where is the mother?'…" (FGD: Maweni, 2024).

A key informant also explained that:

"…men fear how their peers and friends will perceive them. They will say the main is being controlled. Some men are also challenged by their relatives to stop doing a woman's job…" (KII, Kigamboni, 2024)

The above findings revealed that some men were discouraged from being actively involved in maternal health care by the fact that other members of their community mocked them. Those reported to have accompanied their partners to the antenatal care clinics were considered less men by their peers. Due to this cultural barrier, it is important to understand that most men are not comfortable accompanying their partners to antenatal clinics for fear that they will be embarrassed or mocked by their peers. The current findings concur with what was concluded by Mahiti et al. (2017) that if a man accompanied his partner to the clinic, he risked being perceived as controlled by the partners and, therefore, may end up being criticized by others. Similar findings were also reported by Aura (2014), who also found that men had been discouraged from accompanying their partners to the clinic for fear of being ridiculed by their peers as being jealous and over-protecting their partners. To protect their masculinity, which is built on cultural norms, men tend to avoid engaging in activities that will make their community question their masculinity. Therefore, it is imperative to advocate for programs and education to address fear stigma and build confidentiality through targeted interventions to improve male partners' willingness to participate in maternal health care.

4.3.2 Perception of maternal healthcare as culturally women's domain

There was consensus among respondents in FGDs on pregnancy and childcare, a domain for women. The discussion was dominated by the idea that the male partner's role is limited to financing maternal health, transport costs and food provision. Still, it discouraged men from actively taking part in antenatal care. The discussion further questions the name of maternal health care, even in the local language, refer as kliniki ya mama na mtoto (meaning Mother and Child Clinic). This perception made other men think that maternal health care was specifically for women and their children. Similarly, since men are not medically affected, few services target them as compared to those that target women and children, giving them a leeway not to take part in antenatal care actively. It was further described below:

"…Most services at the clinic are for women, and even if you go there as a man, you will end up doing nothing. Even when they provide free protective material such as mosquito nets, they target women and children. They don't know our existence then…" (FGD: Kigamboni, 2024).

It is worth noting that, in Tanzania, those clinics are even named mother and child clinics (MCH), leaving male figures out of the picture in maternal and child health. This element discourages some men from going there since they feel not needed. With this notion, most men conclude that they do not have to be at the clinic, and their physical presence will, therefore, have minimal health outcomes for their partners and children.

Male partners reported feeling unwelcome and misunderstood when attempting to take an active, supportive role in antenatal care. Many described a sense of exclusion, often treated as outsiders or merely temporary visitors at antenatal clinics. This lack of acceptance left them disheartened, as their involvement efforts were overlooked and sometimes questioned. The prevailing societal expectations that frame maternal care as solely a woman's responsibility reinforced their marginalization and diminished their confidence in continuing their support. A respondent revealed:

"… When people see me carrying a baby to the clinic, they ask me, 'Where is the baby's mother?' When I say that his mother has gone to work, people don't understand. Going back to the antenatal clinic issue, it seems like an activity for females and a man is not needed unless it's the first visit when couples are required for initial examinations…" (FGD, 2024).

In addition, the key informant reported some beliefs related to men's involvement, which is common in coastal areas like Kigamboni. One nurse reported her experience working in the community and mentioned that some men would not accompany their partners to labour, which would mean more pain to their partners and delays. She described it as follows:

"…I heard a man saying that there is a belief that if a man went to the labour room with his wife, the wife would experience more pain and prolonged labour. Thus, most men avoid accompanying their partners to the clinic because they think it will lessen the pain and ease the labour process…" (MCH Nurse: Kigamboni, 2024).

A study by Mahiti et al. (2017) also found culture as a barrier to maternal health care in Tanzania, where most men had been streaked from participating in maternal and child health because, in their culture, it was considered a women's issue. In South Africa, Nesane et al. (2016) also found similar results: men perceived maternal and child health as women's domain; thus, going to the clinic should be their duty. In the current study, participants raised the point that they had not been willing to take part in maternal health care since it was uncommon for a man in their community to do so since it is considered a "women's issue".

4.3.3 Nature of work (Economic barrier)

It was also noted that most men experience limited time to be at the clinics together with their partners, also challenged by their gender role as breadwinners. The time and nature of work performed by individual men, which is further complicated by long waiting times for the services at the clinics, limits male involvement in maternal health care. Most men were barred from getting involved in maternal health care due to their nature of work and their schedule. Results on occupation of respondents (Table 1.) indicated that the majority of them were privately employed (44%) and self-employed (24%). They can engage in a maternal health care clinic by requesting permission or closing their business when they are at the clinic. It was described in the following quote:

"…I work as boda boda (motorcycle) driver, I cannot leave the business unattended. If I decide to close for the day, I will not have any money to bring to the owner since I am a day worker. So, I just let her go while I am busy working…" (FGD: Kibada, 2024).

The majority saw accompanying their partners to maternal health care as a missed opportunity to work and provide for their families. Most reported working in the informal and private sectors where you only earned when reported to work, unlike government employees who are guaranteed a monthly salary. During GD, respondents expressed their frustration with the time they spent in the clinics waiting for services while they had business to attend to serve their families. It was quoted that:

"…we may escort our partner to the clinic. But you may find that it takes much time to get services, we get impatient and decide to leave so that we can attend other work matters to earn our daily bread…" (FGD: Maweni, 2024).

Another respondent revealed:

"…my job requires me to work long hours and often on weekends; therefore, I don't have much time to be involved in accompanying my partner to maternal health services. I sometimes need to support my partner, but the nature of work does not allow me to do so…" (FGD: Kibada, 2024).

The above findings indicated that job demand may contribute to low male involvement in maternal health care with their partner. Services offered during maternal and child health clinics, like health education talks, a child weighing, and medical examination of the mothers, may take more than two hours, most of which men would not stand as they have work-related issues to attend. A study conducted by Aura (2014) reported that men did not actively participate in their partner's maternal health care because they had been busy at work. Thus, economic activities that men get involved in are key determinants of how they will be involved in activities outside their work, such as escorting their partners to maternal health care clinics, especially during the day.

4.3.4 Service-related barriers

Participants revealed that the general attitude of the healthcare providers towards male involvement in maternal health care was mentioned as another barrier. Sometimes, male partners were told to wait outside the consultation rooms while their children and partners were being attended to; therefore, they felt unwelcome. It was further narrated in the following quote:

"… sometimes when we accompany our partners to the clinics, we sit idle at the benches. It makes us feel we have wasted our time…" (FGD: Kibada, 2024).

Respondents also complained of bad language and disrespectful treatment. Participants of FGD reported that healthcare workers asked questions that embarrassed them, which they consider private, making them uncomfortable being there. One said:

"… At the clinic, they ask a lot of questions, which makes me feel embarrassed to be there while they are asking my partner, such questions as; what was her last menses and when was the last time we had sex without a condom question that I cannot withstand as a man and therefore I choose not to go there…" (FGD: Maweni, 2024).

The above findings suggest that such embarrassing moments are known to keep some men away and limit their visits to the clinic, as well as how they will actively be involved in accompanying their partners to antenatal care. A study by Byamugisha et al. (2010) in Uganda also found that some men were discouraged from going to the antenatal and postnatal clinics due to embarrassing questions they were asked. In this study, some men mentioned that they were met with unwelcoming healthcare providers at the clinics, discouraging them from accompanying their partners during subsequent visits. Most men fear going to the clinics because of the treatment they would get from the health providers and for fear of being harassed. Therefore, it is crucial to say that a healthcare provider's attitude plays a critical role in determining the level of male involvement in maternal healthcare.

5. Conclusion and recommendations

The status of male involvement in maternal health care in Kigamboni District, Tanzania, is low. By employing the Socio-Ecological Model (SEM), this study was able to understand the cultural, economic and health-related factors that barred men from actively participating in maternal health care in

Kigamboni district. These factors determine how much these men are involved in maternal health care. The study revealed that some socio-demographic backgrounds of respondents (age, education and occupation) and independent factors (socio-cultural norms, perception of maternal health as a women's issue, economic factors and service-related factors) are associated with male involvement in maternal health services. The majority of male partners had misconceptions that maternal health care is solely the responsibility of women. However, male partners who attended maternal healthcare sessions were more likely to provide financial and logistical support for healthcare utilization. Thus, to enhance male involvement, targeted educational campaigns, active engagement by healthcare providers, and community-based initiatives promoting positive attitudes toward male involvement are recommended. Public interventions should focus on designing messages considering the disenabling factors discussed in this study. Specifically, educational campaigns to help diffuse the existing cultural norms and perceptions of men's attitudes towards involvement in maternal health care. These efforts can lead to improved maternal and child health outcomes in the community and Tanzania at large.

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