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Original Article

Enhancing Men's Participation in Maternal Health Care Services: An Analysis of Socio-Economic Predictors in Arusha City

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Male Participation, Maternal Healthcare, Socio-economic Factors, Cultural Norms, Antenatal and Postnatal Care, Probit Regression.

ABSTRACT

This study examines the socio-economic factors that hinder men's participation in maternal healthcare services in Kaloleni and Ngarenaro wards, Arusha, Tanzania. Although male involvement is crucial for improving maternal and neonatal outcomes, particularly in antenatal and postnatal care, men's engagement remains limited due to several persistent barriers. Probit regression analysis revealed that economic constraints ($\beta = 1.502$, $p < 0.001$), cultural norms ($\beta = 1.678$, $p < 0.001$), limited access to healthcare services ($\beta = 1.134$, $p < 0.007$), and time constraints ($\beta = 2.273$, $p < 0.001$) are significant obstacles to men's participation. Conversely, education on maternal health ($\beta = 1.245$, $p < 0.001$) was found to have a positive impact on involvement. These findings underscore the critical need for targeted interventions that challenge traditional gender roles and raise awareness of the benefits of male participation. The study advocates for comprehensive, gender-sensitive policies and strategies, including enhanced healthcare accessibility, culturally appropriate educational campaigns, and the development of inclusive maternal health policies. Addressing these barriers is essential for increasing male involvement in maternal healthcare, thereby improving maternal and neonatal health outcomes and contributing to the achievement of Sustainable Development Goals related to health and gender equality.

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INTRODUCTION

Male involvement in maternal health care remains a significant challenge, especially in low- and middle-income countries, where maternal and neonatal mortality rates are disproportionately high (Angusubalakshmi *et al*., 2023). Every year, approximately 210 million women become pregnant, with 15% facing complications and over half a million dying due to pregnancy or birth-related issues (Clark *et al*., 2020). The World Health Organization (WHO) highlights that 99% of maternal deaths occur in developing countries, where a woman's lifetime risk of dying from treatable or preventable pregnancy complications is considerably higher compared to developed regions (Gibore *et al*., 2019). Despite the global awareness of these issues, many countries continue to view maternal health care as primarily a woman's responsibility, leading to a lack of male engagement in critical services such as antenatal care (ANC) clinics and postnatal care services (August *et al*., 2016). The role of men in maternity care is particularly underexplored in Africa, despite their significant economic power and decision-making influence within households (Finlayson *et al*., 2023). In many African communities, men's involvement in maternal health services, particularly during antenatal and postnatal care, is hindered by cultural perceptions that maternity issues are solely women's concerns (Jennings *et al*., 2014). This belief limits their participation in supporting their wives during pregnancy and childbirth, which, in turn, exacerbates complications and poor maternal health outcomes (Konlan *et al*., 2020). The lack of male participation in maternal health care is not only a cultural barrier but also a critical factor contributing to high maternal and neonatal mortality rates.

In Tanzania, the decline in neonatal mortality from 40 per 1,000 live births in 1999 to 25 per 1,000 in 2015-2016 signals progress, but the country still falls short of the Sustainable Development Goal (SDG) target of reducing maternal mortality to 70 per 100,000 live births and neonatal mortality to 12 per 1,000 live births by 2030 (Clark *et al*., 2020). This persistent gap highlights the underappreciated role of men in maternal health services, especially given that socio-economic and cultural factors play a crucial role in hindering their involvement (Gibore *et al*., 2019). These factors include economic constraints, lack of time due to work obligations, cultural expectations, and limited access to healthcare services. In the context of Arusha, Tanzania, the issue of male involvement in maternal health care is equally pertinent, given the region's unique socio-economic landscape. Arusha is characterized by a growing population, a mix of urban and rural settings, and a predominance of agricultural and business activities, which significantly influence the social dynamics of family and healthcare practices. In rural areas, where agriculture remains the primary source of livelihood, men are often deeply invested in farming, which can restrict their availability to accompany their wives to maternal health services (Gibore *et al*., 2019). Urban areas, on the other hand, witness a higher prevalence of business-related occupations, where time constraints due to

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work commitments further limit men's participation in maternal health initiatives. This gap in male involvement is further exacerbated by traditional gender norms, which in many cases, still dictate that maternal health issues are solely women's responsibility.

Although there have been efforts to improve maternal health care access, the region continues to face challenges in fully engaging men in maternal health services, a critical gap that impacts both maternal and neonatal outcomes. As a result, addressing socio-economic and cultural barriers to male participation in Arusha could significantly contribute to better maternal health outcomes, aligning with Tanzania's efforts to meet SDG targets and improve health equity in the region. Therefore, this study aims to explore the socio-economic barriers to male participation in maternal health initiatives and provide recommendations for policymakers to address these challenges. Understanding these factors is essential to create strategies that can encourage greater male involvement in maternal health, ultimately improving maternal and neonatal outcomes and contributing to the achievement of SDG targets.

MATERIALS AND METHODS

Research Approach and Design

This study aimed to explore the socio-economic factors hindering men's participation in maternal health care services in Kaloleni and Ngarenaro wards of Arusha, Tanzania. The research employed a cross-sectional survey design, which is suitable for examining the prevalence and patterns of socioeconomic factors influencing men's involvement in maternal health care at a particular point in time (Carr, & Thompson, 2014). The study employed quantitative approaches to provide a comprehensive understanding of the barriers and challenges faced by men in supporting their wives during pregnancy, childbirth, and postnatal care.

Study Area and Population

The study was conducted in Kaloleni and Ngarenaro wards, located in the urban and peri-urban settings of Arusha. These wards were chosen due to their diverse socio-economic characteristics, with Kaloleni being more complex and Ngarenaro being more urbanized. The target population consisted of men aged 18-60 who were either married or had partners who had recently given birth. The total sample size for this study was 70 men, drawn through a combination of purposive and random sampling techniques. Purposive sampling was used to select men who met the inclusion criteria, while random sampling was employed to ensure a balanced representation from both wards.

Data Collection

The data were collected through questionnaires, which were designed to gather information on socio-economic factors such as education level, occupation, income, cultural norms, and access to health services. The questionnaires were pre-tested in Levolosi, a neighbouring ward before being administered to ensure reliability and clarity. A team of trained research assistants, fluent in both Swahili and English, assisted with data collection.

Ethical Considerations

Ethical approval for the study was obtained from the relevant institutional review boards. Informed consent was sought from all participants before data collection, ensuring that they understood the purpose of the study, the voluntary nature of their participation, and their right to withdraw at any point without penalty. Confidentiality was maintained throughout the study, with all personal information anonymized during data analysis and reporting.

Limitations

One limitation of this study was the relatively small sample size, which may affect the generalizability of the findings to the wider population of men in Arusha or Tanzania as a whole. Additionally, the

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reliance on self-reported data may have introduced bias, as participants might have underreported or overreported certain behaviours due to social desirability. Despite these limitations, the study provides valuable insights into the socio-economic factors hindering men's participation in maternal health care services in Kaloleni and Ngarenaro wards.

Data Analysis

Data were analyzed using descriptive statistics, including frequencies and percentages. Furthermore, a probit regression was employed to examine the relationship between socio-economic factors and men's participation in maternal health care services, with the log-odds transformation used to model the probability of men attending maternal health services based on the independent variables.

Model Specifications

This model is appropriate for binary dependent variables, where the outcome represents participation (coded as 1) or non-participation (coded as 0). The probit model assumes a cumulative normal distribution and estimates the likelihood of participation based on the predictors. It is particularly useful in cases where the dependent variable is dichotomous, as noted by (Mbunda *et al*., 2024).

The probit model was specified as:

$$\text{Log}\left(\frac{Pi}{1-P}\right) = \beta_0 + \beta_1 X_{1i} + \beta_2 X_2 + \cdots + \beta_{10} X_{10i} + \varepsilon_i$$

Where:

- P_i is the probability of participating in the i^{th} man, and $1 - P_i$ is the probability of non-participation.
- $\text{Log}\left(\frac{Pi}{1-P}\right)$ represents the log-odds ratio of participating in maternal health care.
- β_0 is the intercept or constant term, representing the baseline odds when all independent variables are zero.
- β_1, β_2,…, β_{10} are the coefficients representing the effect of each independent variable on the log odds of participating in maternal health care.
- X_{1i}, X_{2i}…, X_{10i} the independent variables which could include factors like economic constraints, education level, cultural norms, healthcare access, etc., which are expected to influence men's participation in maternal health services.
- ε_i is the error term, capturing the variation in the decision to participate in maternal health care that is not explained by the independent variables.

Data and Description of Variables

The variables used in the analysis framework are described in Table 1;

Table 1: Variables Description and Management

Variable	Description	Coding	Expected Relationship
Dependent Variable (Y):	Men's Participation in Maternal Healthcare	1 = Participate, 0 = Do not participate	N/A
Independent Variables (X):			
Economic Constraints	Financial barriers affecting participation in maternal healthcare	1 = Agree, 0 = Disagree/None of the above	Negative
Marital Education	Lack of education regarding male involvement in maternal health	1 = Lack of education, 0 = No effect	Negative

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Variable	Description	Coding	Expected Relationship
Cultural Norms	The belief that maternal health is solely a woman's responsibility	1 = Agree, 0 = Disagree	Negative
Access to Healthcare	Availability and accessibility of healthcare services for men	1 = Limited access, 0 = Unlimited access	Negative
Time Constraints	Limited time availability to participate in maternal healthcare	1 = Limited time, 0 = Unlimited time	Negative
Educational Level	The highest level of education attained by the respondent	1 = Secondary/Primary, 0 = College or higher	Positive

Source: *Research construction, 2024*

RESULTS AND DISCUSSIONS

Demographic Characteristics of Respondents

The demographic characteristics of the respondents provide valuable insights into the composition of the study sample and highlight key factors that may influence the findings related to men's participation in maternal health care services. A total of 70 respondents were surveyed, with a balanced gender distribution of 50% male and 50% female. This gender equality in the sample allows for an even comparison of responses and a more holistic understanding of the factors influencing men's involvement in maternal health. This balance is particularly significant, as studies by Gibore *et al*. (2019) emphasize the importance of both male and female involvement in maternal healthcare decision-making, with both genders sharing the responsibility of attending clinic services during pregnancy and after childbirth. This gender parity in the sample ensures a broader perspective on the dynamics of participation.

The age distribution of respondents shows that the majority (91.4%) fall within the age range of 27 to 41 years, with 38.6% in the 27-31 age group and another 38.6% in the 37-41 age group. This suggests that the respondents are in their prime working years, a period typically characterized by family and economic responsibilities. This could imply that the demands of work and financial stability may compete with their ability to participate in maternal healthcare activities. Studies such as those by Finlayson *et al*. (2023) highlight the significance of the age factor, as individuals in this age group tend to be in a life stage where balancing work and family responsibilities can reduce the time and resources available for maternal health services. The focus on this age group is thus particularly relevant to understanding barriers to male participation in maternal health.

In terms of marital status, a majority of respondents (68.6%) were married, which is consistent with the expected family structure within the context of the study. However, 14.3% were unmarried, and 17.2% were widowed, providing a broader perspective on the sample's composition. Married respondents are more likely to be directly involved in maternal healthcare decisions, while unmarried and widowed respondents may have different priorities or experiences. A study by Angusubalakshmi *et al*. (2023) noted that marital status can influence the level of male involvement in maternal health, as married men tend to have a greater sense of responsibility for the well-being of their wives and children, leading to more active participation in maternal health initiatives.

Regarding occupation, the largest group of respondents (52.8%) identified as business owners or business people, followed by 25.7% engaged in farming, 14.3% in technical work, and 7.2% employed in other sectors. The predominance of business owners and farmers reflects the local economic landscape and may also suggest that

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many respondents are primarily focused on their livelihood and financial stability. This aligns with the study by Babalola, & Fatusi (2009), which found that occupations with high economic demands, such as farming and business, can limit men's ability to engage in maternal health services due to time constraints and the prioritization of work commitments over health issues. The study highlights that economic pressures are a significant barrier to men's participation in maternal health.

Table 2: Demographic Profile of Respondents (n=70)

Variables	Category	Frequency (f)	Percentage (%)
Age of respondents	22-26	6	8.6
	27-31	27	38.6
	32-36	10	14.2
	37-41	27	38.6
	Total	70	100
Sex of respondents	Male	35	50
	Female	35	50
	Total	70	100
Educational level	Primary	19	27.17
	Secondary	25	35.8
	College	26	37.18
	Total	70	100
Marital status	Married	48	68.6
	Unmarried	10	14.3
	Widow/widower	12	17.2
	Total	70	100
Occupation	Businessman/woman	37	52.8
	Farmer	18	25.7
	Employed	5	7.2
	Technician	10	14.3
	Total	70	100

Source: *Field data, 2024*

Finally, the educational level of the respondents shows a relatively balanced distribution: 27.2% had only primary education, 35.8% had secondary education, and 37.2% had a college-level education. While these figures suggest a moderately educated population, the diversity in educational attainment highlights the varying levels of awareness about maternal health care within the community. The relatively high percentage of respondents with secondary or higher education suggests that knowledge and attitudes about maternal health may differ across the sample, influencing men's participation. Studies by Mbunda, & Sewando (2024) support this finding, stating that higher education levels are correlated with greater awareness and participation in maternal health services, as individuals with more education are generally more informed about the importance of health care during pregnancy and childbirth. Therefore, the demographic data reveals a sample that is predominantly composed of middle-aged, married individuals with a mix of occupations and educational backgrounds. These factors, particularly age, occupation, and marital status, provide important context for understanding the barriers and opportunities for men's participation in maternal health care.

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Participation Rates

The participation rates observed in this study are consistent with findings from similar research conducted in sub-Saharan Africa. Studies from Tanzania, Uganda, and Kenya have documented male participation rates in maternal health care ranging from 20% to 30%, often hindered by similar challenges such as cultural norms, economic constraints, and limited awareness. For instance, a study by Aarnio *et al*. (2013) in Malawi highlighted that traditional gender roles and societal expectations discouraged men from attending antenatal clinics with their partners. Similarly, research in Tanzania by Angusubalakshmi *et al*. (2023) found that male involvement was significantly lower in rural areas, where patriarchal norms and structural barriers were more entrenched. These findings reinforce the notion that the disengagement of men in maternal health care is not an isolated issue but a regional trend driven by deeply rooted socio-cultural and economic factors. However, studies that implemented targeted interventions, such as couple-focused health education programs, demonstrated improvements in male participation, suggesting that strategic approaches can help address these barriers effectively.

Table 3: Participation Rates of Men in Maternal Health Care Services (n = 70)

Participation	Frequency (n)	Percentage (%)
Participate	18	25.7
Do not participate	52	74.3
Total	70	100.0

Source: Field data. 2024

Determinants of Pen's Participation in Maternal Health Care Services

The logistic regression model assessed the factors hindering men's participation in maternal health care in the study area. The model produced a log-likelihood of -78.35, a deviance of 156.70, and an AIC (Akaike Information Criterion) of 170/70. These results show that the selected variables effectively capture the landscape of men's involvement in maternal health care. Results are further presented in Table 4, as:

Table 4: Probit Regression Results (n = 70)

Factor	Coefficient (β)	Standard Error	z-value	p-value
Economic constraints	1.502	0.442	3.40	0.001
Marital education	1.245	0.353	3.53	0.000
Cultural norms and gender roles	1.678	0.467	3.59	0.000
Access to healthcare	1.134	0.421	2.69	0.007
Time and waiting constraints	2.273	0.367	6.19	0.000
Attitude of healthcare providers	1.897	0.388	4.89	0.000
Age	-0.183	0.098	-1.87	0.062
Education level	0.057	0.067	0.85	0.395
Employment status	0.872	0.322	2.71	0.007

Model metrics: *Log-likelihood= -78.35, Deviance=156.70, AIC (Akaike Information Criterion) = 170/70, Number of Observations=70.*

Economic Constraints (β = 1.502, p = 0.001)

Economic constraints significantly hinder men's participation in maternal health care services. The

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positive and statistically significant coefficient ($p < 0.05$) indicates that financial burdens act as a critical barrier. Men may face challenges due to lost income from time spent accompanying their partners to health facilities, particularly in informal or daily-wage employment settings where any absence translates directly into lost earnings. Additionally, the direct costs of transportation, medical fees, and other healthcare expenses further deter participation. In low-income settings like Tanzania, economic insecurity often forces men to prioritize work and income generation over family health responsibilities. This finding supports previous studies, such as Finlayson *et al*. (2023), which emphasized the role of financial factors in shaping male involvement in maternal and reproductive health. Moreover, in rural areas, healthcare-related expenses may be compounded by the long distances to health facilities and inadequate public transportation options.

Marital Education (β = 1.245, p = 0.000)

Marital education is a strong and statistically significant predictor of men's participation in maternal health care ($p < 0.05$). The positive coefficient suggests that when men are educated about maternal health, childbirth risks, and the importance of their involvement, their likelihood of participating significantly increases. Marital education fosters shared responsibility between partners and helps challenge the traditional notion that maternal health is solely a woman's domain.

Research by August *et al*. (2016) underscores the positive impact of joint participation in antenatal and maternal health classes on maternal health outcomes. Educating men about their role in providing emotional and practical support during pregnancy and childbirth demystifies maternal healthcare, making it more accessible and relevant to them. Additionally, educated men are more likely to appreciate the long-term health benefits for both mother and child, further motivating their involvement. Furthermore, marital education may also help address some of the cultural stigmas associated with male involvement in maternal healthcare. Educating couples together can create a more supportive environment where men feel empowered rather than emasculated by their participation.

Cultural Norms and Gender Roles (β = 1.678, p = 0.000)

Cultural norms and traditional gender roles are significant barriers to men's participation in maternal healthcare services. The highly positive and statistically significant coefficient ($p < 0.05$) demonstrates that entrenched societal expectations continue to discourage men from attending antenatal and postnatal health visits. In patriarchal societies like Tanzania, maternal healthcare is often viewed as a woman's sole responsibility. Many men face social stigma if they accompany their partners to clinics, as this involvement may be perceived as undermining their masculinity or societal role as breadwinners. This finding aligns with Konlan *et al*. (2020), who argue that male involvement in maternal health is stigmatized in communities where traditional norms dominate. Such perceptions hinder men's willingness to support their partners in accessing essential healthcare services, resulting in missed opportunities to promote maternal and child health. Furthermore, rigid gender roles often prioritize men's engagement in income-generating activities rather than health-related responsibilities (Mbunda, & Ndunguru, 2024). Societal expectations may even be reinforced by extended family members, who discourage male involvement in maternal health decisions.

Access to Healthcare (β = 1.134, p = 0.007)

Limited access to healthcare is a significant factor hindering men's participation in maternal health services ($p < 0.05$). The positive coefficient suggests that inadequate or poorly distributed health facilities reduce the likelihood of men's involvement. Geographic factors, such as long distances to clinics, poor road infrastructure, and the absence of reliable public transport, exacerbate the

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problem. Health services that are centralized in urban centres often neglect rural and peri-urban areas, where access challenges are more pronounced. Men are more likely to accompany their partners if health services are easily accessible and located within reasonable distances. This finding is consistent with Aarnio *et al*. (2013), who found that decentralized healthcare services and mobile health clinics in Malawi significantly boosted male involvement in maternal health. Furthermore, access issues are compounded by the operational inefficiencies within healthcare facilities. Men may face additional discouragement due to poorly scheduled clinic appointments, overcrowding, and lack of clear information regarding maternal health services.

Time and Waiting Constraints (β = 2.273, p = 0.000)

Time and waiting constraints represent the most significant hindrance to men's participation in maternal healthcare, with the highest coefficient value ($p < 0.05$). The strong positive coefficient underscores how lengthy waiting periods and rigid health service schedules discourage men from accompanying their partners to clinics. This issue is particularly acute in urban settings like Arusha, where many men juggle multiple jobs or irregular work hours, making it challenging to dedicate long hours to health appointments. Morgan *et al*. (2017) reported similar findings in a multi-country study, showing that the absence of flexible and efficient health services deters male involvement. Additionally, traditional clinic operations, which often prioritize women as the primary clients, overlook men's schedules and logistical challenges. The logistical inconvenience posed by long waiting times often compels men to prioritize income-generating activities over family healthcare responsibilities. Addressing these constraints requires healthcare providers to introduce more inclusive and flexible scheduling systems. Options such as pre-booked appointments, fast-track lanes, and extended service hours are crucial to encourage male participation in maternal healthcare.

Attitude of Healthcare Providers (β = 1.897, p = 0.000)

The negative attitudes of healthcare providers significantly hinder male participation in maternal health services ($p < 0.05$). The positive coefficient indicates that supportive and inclusive provider behaviour increases men's engagement, while dismissive or judgmental attitudes discourage it. Healthcare environments in patriarchal contexts often reinforce traditional perceptions that maternal healthcare is solely a woman's responsibility, marginalizing men's involvement. (Mwije, 2018) highlighted that unfriendly health environments alienate men and contribute to the societal notion that male involvement in maternal healthcare is inappropriate or unnecessary. Male clients frequently face stigma, ridicule, or disregard when they attend antenatal clinics. This discouragement reinforces the perception that their presence is unwelcome. Training healthcare providers on gender sensitivity and creating an inclusive clinic environment are essential steps toward improving male participation. Furthermore, visible communication strategies that encourage men's involvement can help dismantle prejudiced notions surrounding male engagement in maternal health.

Age (β = -0.183, p = 0.062)

Age is marginally significant ($p = 0.062$) and has a negative coefficient, indicating that older men are less likely to participate in maternal healthcare services compared to younger men. The reluctance among older men may stem from their stronger adherence to traditional gender norms that frame maternal health as a woman's responsibility. Conversely, younger men tend to be more open to involvement, as they are often more exposed to changing gender roles and modern health education campaigns. Studies by Yargawa, & Leonardi-Bee (2015) in Kenya found similar trends, where younger generations exhibited greater acceptance of

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paternal involvement in maternal healthcare. The age-related gap highlights a generational shift in perceptions of gender roles and healthcare responsibilities. To overcome resistance from older men, health campaigns should consider age-specific interventions, including mentorship programs where younger men share their positive experiences. Encouraging inclusive community discussions may also help reduce the stigma around older men's involvement in maternal health activities.

Education Level (β = 0.057, p = 0.395)

Education level does not have a statistically significant influence on men's participation in maternal healthcare ($p > 0.05$). Despite evidence from broader health literature suggesting that higher educational attainment correlates with positive health-seeking behaviours, this study finds that other factors, such as time constraints and cultural norms, play a more dominant role in shaping participation decisions. One potential explanation is the pervasive influence of patriarchal norms that persist regardless of education level. Even educated men may perceive maternal healthcare as exclusively a woman's domain. Furthermore, the limited focus on gender-sensitive maternal health education within formal education curricula may leave educated men uninformed about the importance of their involvement. Effective interventions must focus on dismantling deep-seated cultural barriers rather than relying solely on educational attainment (Ndunguru, & Mbunda, 2024). Community-based awareness campaigns and gender-focused training programs tailored to men's needs can help foster positive behavioural changes.

Employment Status (β = 0.872, p = 0.007)

Employment status significantly impacts male participation in maternal healthcare services ($p < 0.05$). The positive coefficient indicates that employed men face more constraints in attending health appointments due to work commitments and scheduling conflicts. Employment obligations often result in missed clinic visits, as many employers do not offer sufficient flexibility for paternal health involvement. Konlan *et al*. (2020) found similar trends in Uganda, where rigid workplace policies prevented employed men from accompanying their partners to healthcare services. This challenge is particularly pronounced in the informal sector, where workers often lack job security or paid leave options. Without supportive policies, men are forced to prioritize their employment responsibilities over family health needs. Addressing this issue requires policy reforms that encourage workplace flexibility, such as paternity leave provisions and employer-supported health appointments (Mbunda, 2024). Additionally, introducing healthcare services with extended operating hours or weekend clinics can help employed men access maternal health services without compromising their work obligations.

CONCLUSION AND RECOMMENDATIONS

Conclusion

This study highlights critical demographic and social factors influencing men's participation in maternal health care services in Arusha City. Despite the presence of a moderately educated and economically active population, participation rates remain low, with only 25.7% of men actively engaging in maternal health care. Key barriers identified include economic constraints, rigid cultural norms and gender roles, limited access to healthcare services, time and waiting constraints, as well as negative attitudes from healthcare providers.

Recommendations

Based on the study findings, it is recommended to address the issue of long waiting times by establishing fast-track services or dedicated male-friendly clinic hours to accommodate men's work schedules. Training healthcare providers on gender-sensitive communication is crucial to fostering a supportive environment that encourages male involvement. Additionally, targeted awareness campaigns should challenge cultural norms that

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view maternal healthcare as solely a woman's responsibility, promoting shared parental roles. Economic barriers can be mitigated through financial incentives or subsidies to reduce the cost of healthcare access. These targeted interventions will help overcome critical obstacles and foster greater male participation in maternal healthcare services.

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