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Original Article

Barriers and Enablers of Male Involvement in Maternal and Child Health: Insights from a Gendered Perspective in Rural Mwandi, Western Zambia

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ABSTRACT

Male involvement in maternal and child health (MCH) is a vital pathway for addressing gender disparities in maternal and newborn care. However, in many African low- and middle-income countries, including Zambia, male participation remains a significant challenge. This study explored the factors influencing male involvement in MCH in Mwandi District using a qualitative case study design. Data was collected through in-depth interviews and focus group discussions with frontline healthcare workers and community members and analyzed using inductive thematic analysis in Nvivo software. Findings revealed that economic constraints, traditional gender roles, cultural beliefs, and limited knowledge about maternal health significantly hinder male involvement. Men often prioritize breadwinning responsibilities, while cultural norms perceive MCH as a woman's duty. Nonetheless, younger men demonstrated a more progressive attitude toward shared responsibilities in parenting and maternal health. The study concludes that despite low male participation due to these barriers, community-based programs and government initiatives are making gradual progress in fostering male involvement. Evidence-based recommendations were provided to address the barriers and enhance male participation, ultimately improving health outcomes for women and children.

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INTRODUCTION

The recognition of male involvement in reproductive, maternal, and child health programs has grown significantly since the mid-1990s, particularly following the Cairo and Beijing conferences that underscored the substantial benefits of engaging men in such initiatives (Angusubalakshmi et al., 2023). The Beijing Conference, for instance, included Commitment 8, which emphasized promoting partnerships between men and women in household responsibilities and reproductive health. This highlights the critical role of male involvement in fostering family health and community well-being. Perkins et al. (2016) argue that collaborative health efforts between men and women can yield healthier and more productive populations, which are integral to economic development. Moreover, the World Health Organization (WHO) has identified male involvement as one of eight "strong recommendations" for promoting maternal and child health (WHO, 2021).

Male involvement in maternal and child health (MCH) is defined and understood differently across various studies and institutions. According to the WHO (2021), male involvement refers to providing reproductive health services for both men and women in ways that address their needs as individuals and as partners. Muloongo et al. (2019) further define it as a social and behavioural shift necessary for men to take more responsible roles in MCH, including supporting their spouses socially and economically, as well as participating in family planning and HIV prevention. This study conceptualizes male involvement in MCH as the active engagement of men in women's reproductive health and children's health, recognizing their essential roles as fathers, partners, caregivers, and community members.

Globally, male involvement in MCH is acknowledged as crucial for improving health outcomes but remains limited due to cultural, social, and systemic barriers. Research shows that male participation enhances reproductive health decisions, contraceptive use, and maternal and infant health outcomes. However, traditional gender norms often label reproductive health as a woman's domain, while health systems fail to accommodate male engagement (Doyle et al., 2018). In sub-Saharan Africa, these challenges are exacerbated by patriarchal cultural systems that hinder men's participation in family planning and maternal care. For example, secret contraceptive use among women, which ranges from 6% to 20%, reflects unequal decision-making power in relationships (Tesfa et al., 2022). Additionally, cultural pressures in countries like Ethiopia often compel women to have large families due to male dominance (Sarnak et al., 2022).

In Zambia, male involvement in MCH mirrors the broader challenges seen across sub-Saharan Africa, compounded by deeply ingrained cultural norms. Zambian men are often hesitant to accompany their partners to health facilities, fearing it diminishes their masculinity (Mulenga et al., 2020). Moreover, healthcare facilities frequently lack male-friendly

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services, further discouraging participation. While the National Health Strategic Plan (2022-2026) includes objectives to improve contraceptive use and family planning through male involvement, the lack of a comprehensive policy framework limits these efforts (Mubambe et al., 2024). As Muia, et al. (2022) highlight, male decision-making power in reproductive health remains influential but underutilized in improving maternal and child health outcomes.

Addressing these gaps requires evidence-based interventions informed by both men's and women's perceptions of male involvement in MCH. For instance, Chavane et al. (2018) note that delays in recognizing obstetric emergencies, reaching healthcare facilities, and receiving adequate care are major contributors to maternal mortality. Male engagement can mitigate these delays by fostering early health-seeking behaviours and supporting timely interventions. However, cultural and systemic barriers must be addressed to create an enabling environment for male participation. This study seeks to investigate the factors that facilitate or hinder male involvement in maternal and child health (MCH) in Mwandi District, with the goal of providing actionable recommendations to guide policy and program development for improved health outcomes. Specifically, it aims to explore the extent of male involvement in MCH and to identify the barriers and enablers influencing their participation. By addressing these aspects, the study will offer insights into how male engagement can be enhanced to support maternal and child health, ultimately contributing to more effective healthcare interventions.

MATERIALS AND METHODS

Study Site

The study was conducted in Mwandi District, located in the southern part of Western Province, Zambia, covering an area of approximately 8,000 sq. km and a population of about 42,075 (ZamStat, 2023). The district is predominantly inhabited by the Lozi ethnic group, known for patriarchal traditions that shape male-dominated family structures and decision-making, including health-related issues. Subsistence farming, fishing, and small-scale trading form the backbone of the local economy, with maize, groundnuts, and cowpeas as staple crops. The district's health system consists of seven Rural Health Posts, four Rural Health Centers, and two first-level hospitals: Lutaba Mini Hospital and Mwandi Mission Hospital, the latter serving as the main referral centre due to Lutaba's infrastructural limitations. Community health services are supported by Neighborhood Health Committees (NHCs) and Community Health Assistants (CHAs), with financing coming from government funding, the National Health Insurance Scheme, and local NGOs, despite challenges such as irregular funding and insufficient resources.

Justification for the Study Location

Mwandi District faces significant Maternal and Child Health (MCH) challenges, with a Maternal Mortality Rate of 187/100,000 and an Under-Five Mortality Rate of 3.3% (Mumba, 2021). Rural districts like Mwandi experience high mortality rates due to preventable conditions, including neonatal sepsis and poor healthcare access, as highlighted by Kamanga et al. (2023) and UNICEF (2021). The district's patriarchal norms further hinder male participation in MCH, contributing to poor health outcomes. Previous initiatives, such as the "Men Taking Action" project, aimed at increasing male involvement in MCH, yielded minimal results due to sustainability issues. Consequently, this study was conducted in Mwandi to explore the factors influencing male involvement and to understand the perceptions of both men and women, with the ultimate goal of providing evidence-based recommendations to improve MCH outcomes in the district.

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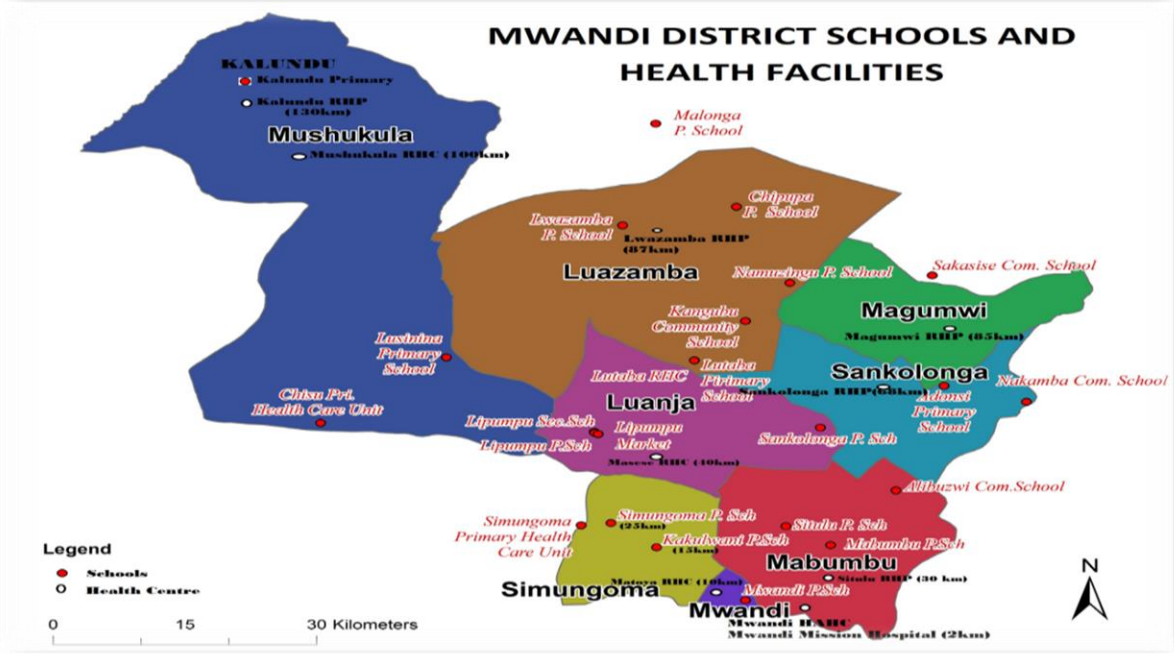
Fig 1: Map of Mwandi District With Its Health Facilities Where the Study was Conducted.



Source*: https://en.wikipedia.org/wiki/Western_Province, Zambia.*

Research Design

The study employed a case study design to explore male involvement in Maternal and Child Health (MCH) and the perceptions of men and women regarding this issue (Coe et al., 2021). This approach facilitated an in-depth analysis of factors influencing male participation, including cultural beliefs, practices, and personal experiences. Data collection methods included in-depth interviews, focus group discussions, and participant observation, while thematic analysis was used to identify and interpret key patterns and themes. This design provided valuable insights into the contextual factors affecting MCH in Mwandi District, offering evidence to inform policy and program development.

Study Participants

The study participants included adult women and men above eighteen (18) years old who were able to provide constructive feedback during the study. In addition, men and women with at least last child below the age of five and married or not married. These desired properties constituted the study sample population. Others were Community Health Workers, Community Health Assistants and trained Health Care workers at both the health facility level and the District Health Office (DHO).

Sampling Procedure

In this qualitative research, purposive sampling was used to ensure a broad representation of different stakeholders, applying a maximum variability approach to capture diverse perspectives. Data were collected from eight health facilities across Mwandi District, carefully selected to encompass various levels of healthcare. The sample size for each group is as follows:

- Two Health Centers (HCs): Data was collected from 2 Health Centers, with 10 healthcare providers selected from each centre.
- Two Rural Health Posts (RHPs): Data was collected from 2 Rural Health Posts, with 5 healthcare providers selected from each post.

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- Two Primary Health Care Units (PHCs): Data was collected from 2 Primary Health Care Units, with 6 healthcare providers selected from each unit.
- One Mini Hospital: Data was collected from the Mini Hospital, with 8 healthcare providers selected.
- One First-level Hospital: Data was collected from the First-level Hospital, with 10 healthcare providers selected.

The selection process included:

- Convenient Sampling was used to select the Mini Hospital and the First-level Hospital, as these were the only hospitals in the district.
- Multi-stage Sampling was employed for the remaining facilities:
  - Stage 1: Simple random sampling of the four Health Centers to select two.
  - Stage 2: Simple random sampling of the eight Rural Health Posts to select two.
  - Stage 3: Simple random sampling of one Primary Health Care Unit (PHC) from the two selected Health Centers' PHCs.
  - Stage 4: Simple random sampling of one Primary Health Care Unit (PHC) from the two selected Health Posts' PHCs.

This method ensured that various healthcare levels and settings were represented, allowing for a wide array of views and perceptions from both healthcare providers and community members. By using maximum variability sampling, the study aimed to include diverse voices, enhancing the richness and relevance of the qualitative data.

Data Collection

Data collection involved Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs). FGDs were conducted with approximately 160 participants, selected through purposive sampling with the assistance of Health Centre Advisory Committee (HCAC) Chairpersons. These included community opinion leaders, such as traditional leaders, women's associations, church representatives, and Community Health Workers (CHWs) from Primary Health Care Units (PHCs). To encourage open discussions, participants were divided into sex-disaggregated groups and met at central locations. IDIs were conducted with health professionals from eight health facilities and four key representatives from the District Health Office, including the District Health Director and the Maternal and Child Health Coordinator. Audio recordings were made with consent for accurate transcription, and trained research assistants facilitated FGDs. To ensure confidentiality, names were excluded from questionnaires, and data collection tools were securely stored for at least three years.

Eligibility Criteria

Inclusion Criteria

- Married or single-headed women with at least one child under the age of five.
- Men aged between 18 and 49 years and up to 69 years for those in the older age group.
- Members of community health structures, including Neighborhood Health Committees (NHCs).
- Traditional leaders, church leaders and Community Health Workers.
- Trained health care staff from all respective study sites.

Exclusion Criteria:

- Individuals with mental illness, regardless of marital status.
- Individuals who chose not to provide consent to participate in the study.

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Validity and Reliability of the Instruments

The internal validity of the study was strengthened by employing multiple data collection methods, including Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs). This triangulation of data sources allowed for a more comprehensive understanding of male involvement in Maternal and Child Health by capturing a range of perspectives from both community members and health personnel. However, the external validity was limited to health institutions within Mwandi District. While the study provided valuable insights into the local context, generalizing the findings to other settings should be approached with caution, especially considering cultural differences. Reliability was enhanced by using consent forms to make audio recordings during interviews and discussions, which facilitated accurate data transcription and analysis. This method helped in capturing the nuances of participants' expressions and ensured the fidelity of the data collected. To address potential researcher bias, the study maintained transparency throughout the data collection process, which contributed to the reliability and trustworthiness of the findings.

Data Analysis Plan

Narrative Content Analysis was employed to uncover recurring themes related to community perceptions of male involvement in Maternal and Child Health. The analysis involved transcription of all recordings during both Focused Group Discussions (FGDs) and In-Depth Interviews (IIDIs). This was followed by immerse reading and proofreading of the data ensuring all the insights were captured from the recordings. Thematic coding was then done on the transcripts generated and NVivo software was used to organize and code the qualitative data, facilitating the identification and categorization of key themes and patterns. This approach provided insights into the perspectives of healthcare workers and community members about male participation in Maternal and Child Health within Mwandi District. The analysis sought to elucidate various factors affecting male involvement and used these findings to recommend targeted interventions at both the community and health facility levels to improve male engagement in Maternal and Child Health (MCH).

RESULTS

Demographic Characteristics of Participants

Table 1 indicates the demographic characteristics of the participants in this study; highlighting an unbalanced representation of gender, with male participants (43%) and female participants (57%). The majority of participants fell within the age group of 26-35 years (40%), followed by those aged 36-45 years (30%). The educational background of the participants varied, with the largest group having attained primary education (40%), while a smaller proportion had tertiary education (14%). The majority of participants were married (60%), and a significant portion were engaged in farming (40%), reflecting the rural context of Mwandi district. These demographics provide a diverse cross-section of the community, ensuring that the findings reflect a broad range of experiences and perspectives related to male involvement in maternal and child health.

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Table 1: Demographic Characteristics of Participants

Demographic Variable	Category	Frequency (n)	Percentage (%)
Gender	Male	74	43%
	Female	98	57%
Age Group	18-25 years	34	20%
	26-35 years	69	40%
	36-45 years	52	30%
	46+ years	17	10%
Education Level	No formal education	28	16%
	Primary education	69	40%
	Secondary education	52	30%
	Tertiary education	24	14%
Marital Status	Married	103	60%
	Single	34	20%
	Divorced/Separated	17	10%
	Widowed	17	10%
Occupation	Farmer	69	40%
	Trader	34	20%
	Employed (formal sector)	28	16%
	Employed (informal sector)	41	24%

Barriers to Male Involvement in Maternal and Child Health

The analysis identified several factors through themes that influence male involvement in maternal and child health within Mwandi District. Economic constraints and prioritization emerged as significant barriers, with many men citing the need to fulfil their role as primary breadwinners, which often limits their availability to participate in health-related activities. Additionally, there were notable awareness and knowledge gaps, as many men were either unaware of the importance of their involvement or lacked the necessary information to participate effectively. Traditional-level factors played a critical role, with gender roles and societal expectations discouraging men from engaging in what is perceived as a predominantly female domain. Finally, the influence of interpersonal-level factors was evident, as supportive initiatives were seen to facilitate male involvement, whereas the absence of such programs in certain areas hindered it.

Gender Roles and Nature of Work

From the study, time constraints and the nature of work were significant factors that limited male involvement in maternal and child health. Many men in the study mentioned that long working hours or shift work left them with little time to be actively engaged in MCH issues. Work demands also prevented men from devoting attention to maternal and child health. Participants explained that prioritizing such responsibilities often came at the cost of direct involvement in household maternal and childcare. This was captured in the following quotes:

> *"Most of us [men] are at work, in places where if you ask for permission from work constantly then you can be fired. I think there is also embarrassment when some men want to get involved in doing such things, they just want to be able to provide food." (FGD M/42 Married)*

> *"My job requires me to work long hours and often on weekends, so I don't have much time to be involved in my family's health issues. I wish*

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> *I could do more, but it's just not possible with the demands of my work." (IDI M/35 Married)*

In the focus group discussions (FGDs), divergent views emerged regarding male involvement in maternal and child health (MCH) services. For instance, while some female respondents felt that men often appeared too busy to accompany their partners to clinics, they also expressed that men frequently provided excuses to avoid attending. A female respondent shared, "*Men say they are busy, but honestly, I think they just don't want to go. It's like they always have some excuse not to come*" *(FGD F/30 Single).*

In contrast, there were reports from other respondents about positive experiences when men participated in MCH services. One female participant highlighted that some health facilities encouraged male involvement by giving priority to men when they attended clinics: "*I know some places where, if a man goes to the MCH or U5 clinic, they put him at the front of the queue. They really appreciate when men come" (FGD F/28 Married).*

These differing perspectives suggest a lack of consensus among respondents regarding male participation. While some believe men avoid involvement, others pointed to strategies used by health facilities to encourage and appreciate male presence.

> *"It's not even an issue of time, they could be at home after work, but I don't know why most men won't just go to the clinic each time they are asked to." (FDG F/35 Married)*

Personal Views and Values

Male involvement in Maternal and Child Health (MCH) is a complex issue, deeply rooted in cultural norms, gender roles, and personal beliefs about familial responsibilities. Within the conceptual framework of the gendered division of labour and socio-cultural constructs of masculinity, it becomes evident that men often see their primary role as providers rather than active participants in the day-to-day healthcare decisions of their families. This deeply ingrained notion shapes their limited involvement in areas like nutrition and routine health check-ups, which are perceived as outside their domain.

In several focus group discussions, it was revealed that men typically felt disengaged from the core responsibilities related to child health, such as ensuring proper nutrition or participating in preventive health services. Their sense of responsibility appeared primarily tied to income generation, which they considered their primary means of contributing to the family. This reflects the broader conceptual understanding that male roles are often associated with the provision of financial resources, a role that they believe sufficiently fulfils their obligations to family well-being.

One male participant's comment, "*We focus on work because that is how we take care of the family,"* underlines this perspective. Men believed that their role in working and providing income was a way of prioritizing their family's welfare. However, this belief created a disconnect between income generation and direct involvement in maternal and child health-related decisions. As a result, men distanced themselves from everyday health practices like attending maternal or child health clinics.

From a gender and power relations perspective, this distancing reflects deeper issues of gender inequality, where caregiving and health-related responsibilities are still largely seen as female domains. Men's roles as financial providers are perceived as superior or more critical to family survival, which inadvertently marginalizes their participation in non-financial aspects of family health.

Moreover, this dynamic is perpetuated by the patriarchal structures embedded within many communities, where men hold significant authority over major family decisions, yet delegate healthcare

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roles to women. This reinforces the perception that attending clinics or engaging in nutritional discussions are secondary tasks, not worth the time of men who feel their labour outside the home is of greater importance.

However, contradictions in male involvement were also noted. In some health facilities, strategies were employed to encourage male attendance at MCH clinics. Reports of men being given priority in queues at clinics show that structural efforts to shift norms are being made in some contexts. As one respondent observed, "*In some places, when a man comes, they put him at the front of the queue.*" This suggests that there are attempts to challenge traditional gender roles and incentivize male participation in health matters, yet these efforts are still seen as isolated instances rather than widespread practices.

While thematic saturation was largely reached on the topic of male perceptions and roles, dissonances still emerged around the reasons for their absence in MCH services. On the one hand, men perceived themselves as fulfilling their responsibilities through income generation, and on the other hand, there were indications that health facilities were beginning to recognize and reward male participation. These contradictions highlight the evolving nature of gender roles in healthcare but also suggest the need for more comprehensive strategies that can reshape deep-rooted beliefs about the responsibilities of men in health-related matters.

These men cited the provision of finances for purchasing food as a key contribution they made to the family as exemplified in the following excerpts:

> *"I provide her with what she requires since she spends most of the time with the child …. I am 100% involved in their welfare." (IDI M/25 Married)*

> *"When my wife was pregnant, I ensured that I provided all the things she required such as food and transport money for clinic visits." (FGD M/21 Married)*

Women respondents as shown below generally confirmed the view of men as providers of their families:

> *"My husband leaves the responsibility to me so that I take care of the baby, he provides the money and leaves the other responsibilities to me." (FGD F/28 Married)*

Most men mentioned assisting with logistics, finances, and accompaniment to the clinics when it came to maternal and child healthcare. Most men viewed health care, particularly pregnancy and childbirth, as a female domain. Only when it was completely necessary would a man accompany their wife to the clinic, but regular visits were considered a waste of time. One man in a FGD indicated,

"Because I have twins, I must help her by accompanying her to the clinic occasionally." (FGD M/43 Married)

It is also notable that the few men who accompanied their wives to clinic appointments did not necessarily go into the healthcare facility or see the doctors with their wives. In an IDI, a health worker indicated,

> ***"****When these mothers come, their partners are usually in the neighbourhood waiting for them to finish with all clinical procedures, then escort their partners back home. They do not usually accompany their spouses into the clinic". (IDI F/28 Single)*

A Health Centre Advisory Committee (HAC) Chairperson corroborated this.

> *"When they go to the clinic [men] they usually stay out and wait for the woman outside the clinic. Most men miss the information in this way." (FGD M/55 married)*

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Knowledge of Maternal and Child Health

Most women noted that their husbands had limited knowledge of what constitutes nutritious food for pregnant women or young children and that they primarily focused on bringing home food regardless of its nutritional value.

> *"Some know a bit about nutrition but most men do not have the skill of preparing nutritious food for their spouses or children" (FGD F/ 43 Married)*

The illustrated themes generated several subthemes. Economic Barriers highlight that men are often the breadwinners, and their focus is on providing for the family, which leaves little time for involvement in health matters. One observer said,

> *"Men typically assume the role of the family provider, leaving them with little time to engage in health matters." (FGD M/40 Married)*

Knowledge and Awareness is another subtheme, pointing out that some men don't know the importance of their involvement in maternal health; they think it's solely a woman's responsibility. One participant observed,

> *"Some men fail to recognize the significance of their role in maternal health, believing it to be the exclusive duty of women." (FGD F/28 Married)*

Supportive Policies and Programs suggest that government programs encouraging male involvement have started to make a difference, but more needs to be done to reach rural areas. A participant discussed,

> *"Programs aimed at increasing male participation like the "Men Taking Action" program in Mwandi are making progress, yet more must be done to ensure these programs reach all the rural areas" (IDI M/45 Married)*

Improved Health Outcomes are assured when men are involved, Women are more likely to attend antenatal clinics, leading to better health outcomes for both mother and child. However, it is a man who usually decides the adoption of good health practices in a home. Lastly, Strengthened Family Relationships emphasize that involvement in child health brings families closer; it shows that men care about their children's well-being.

> *"When men get involved, women are more likely to go to antenatal check-ups, which leads to better health outcomes for both the mother and the baby (IDI M/32 Married)."*

Another participant (SMAG member) discussed,

> *"Being involved in child health has brought our family closer together and shows that we men care about our kids' health too." (FGD M/26 Married)*

Interpersonal Level Factors

Conflict Within the Household

Conflict within the household also made it difficult for men to feel comfortable involving themselves in Maternal and Child Health. Men expressed difficulties in getting "too involved" in matters of child health due to a desire to avoid confrontation. "Too involved" meant doing additional roles to their work as economic providers such as offering advice or suggestions on what food to prepare and sometimes purchasing ingredients required for meal preparation. The men noted that too much involvement could cause problems at home as per these excerpts:

> *"Sometimes when men suggest what should be cooked or even help in preparing meals, our wives start thinking that we want to control their kitchens and decisions in a home. This can lead to arguments. It is easier for us to just stay out of it and stick to providing money. This is what makes it harder for men to really get involved in our children's health." (FDG M/45 Married)*

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A few responses highlighted the women's desire for autonomy in household meal planning, budgeting and procurement of household essentials, therefore, felt that direct engagement by men would be a cause of conflict in the house giving different reasons as exemplified in these excerpts:

> *"Some wives may feel uncomfortable because they want to do the budget since some may want to set aside some money for themselves." (FGD M/27 Married)*

> *"There might be conflicts because most women think they know more about what the child needs. So, you find that in a household there are some disagreements when a man tries to suggest something. It might look to the woman that they are competing. In our community, you will be told that you are competing with your wife over such embarrassing issues" (FDG M/42 Married)*

Stigma and Discrimination

Stigma and discrimination can have a significant impact on male involvement in Maternal and Child Health. Men who take an active role in this area may face negative stereotypes and be viewed as challenging traditional gender roles. This can lead to social isolation, which can discourage men from continuing to be involved in maternal and child Health. Men who were seen to be engaged in "women's business" were stereotyped and gossiped about by fellow men and women. This resulted in negative views such as men being controlled and manipulated by their wives. Some were also seen to be mean as they wanted to control the spending of money meant for the household and others were seen as being idle. On the other hand, women who allowed their husbands to engage in "their work" were seen as lazy:

Some of the responses around this theme are highlighted below;

> ***"****People will say that the man does not want to give the woman money, he is mean. The man buys the food himself; he sees as if when he gives the woman money, some will be left, and the woman will not reveal this but keep it****."*** *(FGD F/28 Married)*

> *"People will say that the man is controlled, and when the man hears that, he thinks that if he goes there [to the health facility], he will not be respected, and people will think that he is being controlled" (FGD F/26 Married).*

> *"Men fear how their image will be perceived in the community and especially by their peers and friends. They also have fear because they think women are controlling them. That makes them feel as if their manhood is violated." (IDI F/20 Not Married)*

Institutional-level Factors

Association with HIV Testing

From the study, accompaniment to the clinic was highly associated with HIV testing. Among the members of the community, it is common knowledge that if you go to the clinics, HIV testing is mandatory. This idea stems from earlier Prevention of Mother to Child Transmission of HIV (PMTCT) campaigns that urged men to be tested for HIV at local health facilities**.**

> *"Men are afraid of knowing their HIV status because when the spouse is pregnant you must have your HIV status checked, so they don't want to keep on going to the clinic****"*** (IDI F/20 Not Married)

Unwelcoming Health Facility Environment

From the study, it was clear that it was mainly women who took children to the health facilities during clinic appointments. Men who did accompany their wives to the clinic reported receiving good treatment from the staff. By providing a welcoming environment and ensuring that men feel valued and respected, healthcare providers encouraged men to be more involved.

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> *"There was a time when I went with my wife to the clinic and I noticed other men in the queue also. I remember that we were served faster as couples than the others who came alone" (FDG M/57 Married)*

> *"The reception was very good the first time. I was informed that most men don't want to accompany their spouses. So, I was encouraged*" *(FGD F/40 Married)*

Levels of Male Involvement in Maternal and Child Health

Some participants perceived male involvement in Maternal and Child Health as outrightly a preserve of women. Detachment of men from attending clinics most especially subsequent Antenatal clinics (ANC) and during child health clinics like Growth Monitoring and Promotion (GMP) was frequently reported. This further perpetuated their poor health-seeking behaviours thereby affecting their household's access to, and utilization of healthcare services. On the other hand, there was a recognition by healthcare facilities that young men were actually becoming more responsive to attending clinics including adhering to antenatal care visits as well as bringing their children for Growth Monitoring and immunization activities. This improved family cohesion and support systems as male involvement fostered stronger family bonds and a shared sense of responsibility. Another significant benefit of active male involvement was the perceived reduction in maternal and child mortality rates, as men's active participation often ensured that healthcare services were accessed in a timely manner. This engagement not only eased the burden on mothers but also created a sense of shared responsibility, ultimately fostering a more supportive and harmonious household environment.

Strengthened Family Relationships

Male involvement in maternal and child health significantly contributes to stronger family bonds. Respondents frequently emphasized the positive impact of active male participation in antenatal care and childcare routines. For instance, one participant noted,

> *"When my husband comes with me to the clinic, I feel more supported and less anxious. It has brought us closer as a couple." (IDI F/32 Married)*

Several participants who mentioned that shared responsibilities and experiences in caregiving fostered a sense of partnership and mutual understanding echoed such sentiments.

One respondent shared,

> *"I noticed a huge difference in our relationship when my partner started being more involved in our baby's routine. It's like we're on this journey together, and it makes our bond stronger." (FGD F/36 Married)*

This perception aligns with the view that male involvement encourages open communication and shared decision-making, reinforcing the family's emotional connection.

Enhanced Health Outcomes

The study also highlighted that male involvement positively influences health outcomes for both mothers and children. Many mothers expressed that having their partners present during medical appointments or actively participating in healthcare decisions increased their confidence and compliance with medical advice. One mother explained,

> *"I remember when my husband attended the ANC visits with me, it made me feel more confident about following the doctor's advice. It's like we were both committed to a healthy pregnancy." (FGD F/34 Married)*

Furthermore, respondents noted that male involvement often led to better health practices, such as regular attendance at medical check-ups and adherence to prescribed treatments.

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> *"With my husband's encouragement, I have been more consistent in taking my supplements and attending all my appointments*," *(IDI F/30 Married)* another participant shared, underscoring the supportive role that men can play in enhancing maternal health outcomes.

Reduction in Maternal Health and Mortality

A critical observation from the data is the perceived reduction in maternal health complications and mortality due to increased male involvement. Several participants reported that when men were actively engaged, there was more timely decision-making in emergency situations and better access to healthcare services. Since men were perceived as sole providers for their homes, responsibilities including arranging for emergency referrals were under their care.

> *"During my last pregnancy, there was a complication, but my husband quickly organized an ox-cart and we got to the clinic in time. His presence saved both our lives," one participant revealed. (FGD F/31 Married)*

The study participants frequently mentioned that male involvement led to better preparedness for emergencies and a more comprehensive understanding of maternal health risks.

> *"My husband is one of the "Men Taking Action" champions, he took the time to learn about the risks of pregnancy, and when I showed signs of distress; he knew exactly what to do, he prepared an ox-cart and quickly took me to the health facility mother's shelter" (FGD F/31 Married)*

Explained another mother, highlighting how male awareness and preparedness can mitigate risks associated with childbirth.

Promotion of Healthier Lifestyles

Lastly, the promotion of healthier lifestyles emerged as a significant benefit of male involvement. Women reported that when their partners were actively involved, there was a noticeable shift towards healthier dietary and lifestyle choices. One respondent shared,

> *"We started eating healthier because my husband wanted to support me during the pregnancy. It's not just about me, but about the whole family being healthy." (FGD F/31 Married)*

Additionally, male involvement was linked to increased physical activity among pregnant women and new mothers.

> *"My husband and I started walking together every evening patrolling our maize field. It became a routine that helped me stay active throughout my pregnancy," (IDI F/31 Married)*

Another participant mentioned, demonstrating how male involvement can promote a culture of health and well-being within the family unit.

Role of Cultural Beliefs and Practices in Shaping Male Participation in Maternal and Child Health

The perception of weakened masculinity due to involvement in Maternal and Child Health (MCH) is deeply rooted in traditional cultural beliefs. In many communities, masculinity is tied to strength, dominance, and a provider role. Men are socialized to view themselves as breadwinners, and any deviation from this norm, such as engaging in caregiving or health-related activities traditionally seen as women's work, is often seen as compromising their masculine identity. In some cultures, this perception is reinforced by specific rites of passage or initiation practices, where men are taught to distance themselves from roles associated with nurturing or caregiving. These cultural ideals may discourage men from taking an active role in MCH, as participating in antenatal visits, childbirth, or childcare could be viewed as a sign of vulnerability or loss of power. However, as you noted, there is a generational shift occurring. Younger men are increasingly questioning these

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traditional norms, particularly as more focus is placed on the benefits of male involvement in MCH, such as improving maternal and child health outcomes, fostering family cohesion, and enhancing the overall well-being of the community. The evolving understanding of gender roles, facilitated by education and awareness programs, is helping to reshape cultural beliefs, allowing more men to embrace caregiving and health roles without feeling that their masculinity is at stake.

In rural or more conservative settings, this change might take longer to manifest, but there is a growing recognition of the importance of male engagement in MCH, not only for the well-being of mothers and children but also for the health of the family unit and society at large. Efforts to deconstruct harmful gender stereotypes and promote positive masculinity that includes nurturing roles are key to enhancing male participation in MCH.

Perceived Weakening of Masculinity

A significant cultural barrier to male participation in Maternal and Child Health is the perception that such involvement leads to a weakening of masculinity. Many respondents expressed that men are often reluctant to engage in caregiving or accompany their partners to healthcare facilities due to fear of being perceived as less masculine. One participant noted,

> *"My husband thinks that attending Antenatal sessions or helping with the baby is something that will make him appear weak in front of his friends. He says it's not what men do." (IDI F/31 Married)*

This belief is deeply rooted in cultural norms that associate masculinity with strength and detachment from domestic responsibilities. As another respondent shared,

> *"In our community, men believe that showing too much concern for women's health is a sign of weakness. They think it's a woman's job to worry about these things. That is why our mother-in-law usually visits to help out with any pregnancy-related issues." (IDI M/31 Married)*

Such perceptions significantly deter male involvement, as they fear judgment from their peers and community members.

Traditional Gender Roles

Traditional gender roles also play a crucial role in limiting male participation in Maternal and Child Health. Many respondents indicated that men are expected to be the primary breadwinners and are not typically involved in caregiving or domestic tasks. One mother explained,

> *"In our culture, men are expected to provide for the family, not take care of the children. My husband believes that taking care of our baby is my responsibility, not his." (FGD F/25 Married)*

This deeply ingrained belief system perpetuates the idea that maternal health and child-rearing are exclusively women's domains, making it challenging to encourage male involvement.

> *"My husband thinks his role ends with providing money for the clinic visits. He doesn't see the need to be present during these visits or to help at home,"* another participant shared. *(IDI F/31 Married)*

This perspective reflects the broader societal norms that shape family dynamics and gender expectations.

Economic Barriers

Economic barriers further restrict male participation in Maternal and Child Health. Many respondents reported that men are often unable to take time off work to attend medical appointments or assist with caregiving duties due to financial constraints.

> *"My husband would love to be more involved, but he works long hours taking care of the cattle, and if he takes time off, we might lose the*

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cattle that we can't afford to lose," one participant explained. (FGD F/22 Married)

Additionally, economic pressures can exacerbate stress and limit men's ability to prioritize involvement in Maternal and Child Health. A FGD participant discussed;

"We struggle financially, and my husband feels like he has to work all the time burning charcoal and selling to provide for us. He doesn't have the luxury to think about attending clinic visits with me," (FGD F/21 Married)

Another respondent mentioned, highlighting how economic challenges can hinder male participation in maternal health matters.

Changing Attitudes

Despite these barriers, the study also found evidence of changing attitudes towards male involvement in Maternal and Child Health. Some respondents noted a growing recognition of the importance of shared parenting responsibilities and a willingness among younger men to break away from traditional norms. One FDG participant shared,

"My husband is different from the older generation. He believes in being there for me and our child. He says it's not just a woman's job." (FGD F/21 Married)

This shift in attitude was particularly notable among younger couples who expressed a desire for more egalitarian relationships as observed by another FGD participant.

"We both decided to be involved equally in everything concerning our baby. It's not about who does what; it's about being partners. The Neighborhood Health Committees (NHCs) and the Men Taking Action (MTA) champions also encourage us to get involved in Maternal and Child Health issues" (FDG M/24 Married)

Another respondent stated, indicating a move towards more inclusive roles and responsibilities in the family.

Community Perceptions and Stigma

Community perceptions and stigma also significantly influence male participation in maternal and child health. Many respondents highlighted that community attitudes often discourage men from engaging in caregiving or attending healthcare appointments**.** (FGD participant indicated)

"In this community, if a man goes to the clinic with his wife, most people will laugh at him. They think he's being controlled by his wife," one participant revealed. (IDI M/26 Single)

Such stigmatization can deter men from participating due to fear of social exclusion or ridicule.

"My husband is an induna (traditional leader) and usually says he wants to help, but he is afraid of what his friends and peers will say. He doesn't want to be the subject of gossip," (FGD F/42 Married)

Another respondent shared. These community perceptions create an environment where male involvement is seen as abnormal, thereby reinforcing traditional gender roles and limiting progress towards gender equity in Maternal and Child Health.

Cultural beliefs and practices explore how traditional gender roles and cultural norms affect male participation in Maternal and Child Health. As indicated by a FGD participant,

"Our culture teaches that men should not be involved in childbirth or child-rearing, as these are seen as women's duties." *(FGD F/50 Married)*

While the other one said,

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> *"While older generations may frown upon male involvement, younger men have more access to information and are beginning to challenge these norms and taking a more active role" (IDI F/28 Single)*

DISCUSSION

The study reveals a significant gap in men's knowledge about Maternal and Child Health (MCH), particularly in relation to nutrition during pregnancy and complementary feeding after six months. This aligns with broader findings that suggest men often lack specific knowledge about the nutritional needs of pregnant women and young children (Mohammed, *et al.* 2019; Alamirew et al., 2025). The data indicate that men are primarily focused on their economic role as providers, ensuring food availability, but without much consideration of its nutritional value. This highlights a critical intersection between traditional gender roles and knowledge gaps in MCH, where men's involvement is often restricted to their role as breadwinners, neglecting the nuances of caregiving and health provision.

The cultural construction of masculinity, which typically positions men outside of caregiving roles, plays a key part in this knowledge gap. As noted by Osamor and Grady (2016), men's involvement in caregiving and health is often seen as a woman's responsibility, reinforcing a gendered division of labour. This structural barrier results in men being less engaged in the practical aspects of family health, such as nutrition and attending medical appointments. Even when men demonstrate some awareness of the importance of a balanced diet, as indicated by the study participants, their understanding tends to be superficial, and they remain disconnected from the implementation of health practices (Mohammed, *et al.* (2019)).

Economic pressures and societal expectations further contribute to men's disengagement from MCH. The emphasis placed on men's role as financial providers often limits their ability to participate in health-related activities, such as attending clinics or learning about pregnancy risks (Olwanda et al., 2023). As several respondents mentioned, the economic demands placed on men leave them with limited time for involvement in household health matters, which are perceived as secondary to their provider role. This separation between economic responsibilities and caregiving exacerbates the gendered division of labour, leaving women to manage the health and nutritional needs of the family (Mkandawire-Valhmu et al., 2020.

However, the study also suggests that men's limited participation in MCH is not solely due to a lack of knowledge but is also influenced by deeply ingrained cultural expectations. The societal stigma surrounding men's involvement in traditionally female roles, such as meal preparation and childcare, can prevent them from engaging in these areas, even when they are aware of their importance. This stigma creates a barrier to men's active involvement in MCH, as they may fear social judgment or undermining women's authority (Chizu, 2021). Addressing these cultural barriers, alongside increasing men's knowledge about MCH, is essential for fostering greater male engagement in family health.

Finally, the study contrasts the findings with evidence from regions where male involvement in MCH has been successfully enhanced through targeted interventions. Programs that educate men about their role in MCH and encourage their active participation have led to better health outcomes in various contexts (Bwalya et al., 2014; Beraki et al., 2023). However, the success of these initiatives is often limited in rural areas where patriarchal norms are more entrenched and healthcare access is limited (Doyle et al., 2018; WHO, 2022). The study underscores the need for culturally sensitive interventions that target both knowledge gaps and the socio-cultural barriers preventing men from participating fully in MCH, particularly in rural and underserved communities. These efforts should focus on promoting shared responsibility in family

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health and challenging the traditional gender roles that limit men's involvement.

CONCLUSION

The findings from this study reveal that male involvement in Maternal and Child Health (MCH) in Mwandi District remains significantly low due to a combination of economic, cultural, and knowledge-related barriers. Economic pressures, where men primarily focus on their roles as breadwinners, limit their time for engaging in health-related activities. Cultural norms and traditional gender roles further reinforce the perception that MCH is primarily a female responsibility, deterring male participation in activities like clinic visits and childcare. Additionally, gaps in knowledge, particularly regarding maternal nutrition and child health, further hinder men's meaningful contribution to family health. However, the study also uncovers a number of enablers, including government policies, community-based programs like "Men Taking Action," and male-friendly health facilities, which show promise in addressing these barriers. Younger generations of men appear more open to shared responsibilities, which presents an opportunity to increase male involvement in MCH. The study successfully identifies both the barriers and enablers, offering valuable insights into how male participation can be enhanced to improve maternal and child health outcomes in the district.

Recommendations

To improve male involvement in MCH in Mwandi District, several recommendations are proposed. First, community-based education programs, such as the "Men Taking Action" groups, should be expanded to educate both men and women about the significance of male involvement in MCH. These programs can address cultural misconceptions, promote gender equality, and emphasize shared responsibilities in ensuring maternal and child well-being. Second, healthcare environments should be made more male-friendly by establishing spaces for men's involvement in various stages of MCH, including antenatal care, delivery, postnatal services, and under-five clinics. Additionally, efforts should be made to reduce the time men spend in health facilities, allowing them to balance family responsibilities while participating in health-related activities. Third, engaging traditional and religious leaders as influential community figures can help promote positive behavioural changes. These leaders can challenge harmful gender norms and encourage men to take an active role in MCH. Economic empowerment programs should also be developed to alleviate financial barriers preventing men from participating in MCH activities, recognizing the importance of balancing their roles as providers with active involvement in family health. Targeted health education initiatives aimed at men can address knowledge gaps, particularly on antenatal care, childhood immunizations, and danger signs during pregnancy. Training healthcare providers, including community health workers, to better engage men in MCH is crucial for ensuring that male involvement is integrated into routine health services. Lastly, further studies should explore the effectiveness of these interventions, as well as the role of socio-cultural dynamics, technology, and policy reforms in promoting male participation in MCH.

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Ethical Approval

The researcher received clearance from the Lusaka Apex Medical University Bio-Medical Research Ethics Committee (LAMUBREC). Permission to collect data from the study site was also obtained from the Board of Graduate Studies and other

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relevant authorities. Participants who took part in the study completed consent forms and were assured of anonymity.

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