BARRIERS TO MALE PARTICIPATION IN ANTENATAL CARE IN NYAMAGANA DISTRICT, TANZANIA

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN MONITORING AND EVALUATION

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CERTIFICATION

The undersigned certifies that she has read and hereby recommends for acceptance by The Open University of Tanzania a dissertation titled, "**Barriers to Male Participation in Antenatal Care in Nyamagana District, Tanzania",** In partial fulfilment of the requirements for the award of Degree of Master of Arts in Monitoring and Evaluation MA(M&E) of The Open University of Tanzania.

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Dr. Harrieth G. Mtae

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Date

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DECLARATION

I, **Alen Kinyina,** declare that, the work presented in this dissertation is original. It has never been presented to any other University or Institution. Where other people's works have been used, references have been provided. It is in this regard that I declare this work as originally mine. It is hereby presented in partial fulfilment of the requirement for the Degree of Master of Arts in Monitoring and Evaluation [MA (M&E)] of The Open University of Tanzania.

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Signature

…….

Date

DEDICATION

I dedicate this dissertation to my daughter Nisa Alen and my wife Dr. Sarah Chamos.

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Special complements go to our Almighty God the Merciful, the creator of mankind, for his endless love and gift of life that he has offered to all of us, strength and guidance throughout our lifetime.

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ABSTRACT

Men participation in antenatal care has been acknowledged by World Health Organization (WHO) as a key factor in improving maternal health and reducing maternal morbidity and mortality in settings where in the household men play key role in decision making. Aspects of reproductive health like family planning and treatment of sexual transmitted infections (STI) such as syphilis and HIV have seen improved where male participation has been promoted. Tanzania has a high maternal mortality rate of 556 per 100,000 live births with a slow decline towards its goal of 140 per 100,000 live births by 2030. Male partner involvement is among the strategies that can contribute to accelerate the decline in maternal mortality and improvement of maternal health. This study investigated about the barriers to male involvement in ANC in Nyamagana district, Tanzania. The study was underpinned by a conceptual framework adapted from Vyonne conceptual framework of male involvement in antenatal care. This study utilized mixed approach of qualitative and quantitative methods. A cross-sectional survey using interviewer administered structured questionnaire was conducted among 201 male partners aged 18 years and above whose partner has delivered within 12 months' prior the interview day. Purposive sampling technique was used to select the sample of respondents. The list of villages was used as the master frame from which 6 villages were purposely selected for the study 2 from rural, 2 from semi urban and 2 from urban to ensure good representation. Selection of eligible men respondents involved random selection of households in each selected village. The FGDs women were selected by nurse on duty at Makongoro Health center basing on the said eligibility until a group of 6-8 women is complete The survey was complemented by four focus-group discussions; two groups were postnatal mothers

and a second two groups of pregnant women with at least 3 ANC visit. Both descriptive frequencies and percentages were carried out; Pearson Chi-Square was used to test association between the various factors and the level of male involvement; and inferential binary logistic regression analyses were carried out to determine the influence of these factors on the level of male involvement. For the focus group discussion results, Thematic Content Analysis was also done. 153 (76.3%) respondents reported men participation in ANC. Men with 50 years and above were less likely to report high male involvement in ANC compared to those who were aged 18–29 years (OR= 1.45, 95% CI= [0.37–1.85], p=0.04. Respondents who were living together with their partners were about two times more likely to participate in ANC compared to those who are not living with their partners (OR =2.15, 95% CI= [1.15–4.02], p=0.01). Lack of health insurance and transport means were significantly associated with poor male participation in ANC. Participants who reported long waiting time at the health facility as a barrier of male participation in ANC were less likely to report high male involvement in ANC compared to those who disagreed (OR=1.55, 95% CI = [1.36–1.83], p =0.002). The findings of this study calls for district health managers and other reproductive health stakeholders involved to strengthen efforts accelerating male friendly policy in social cultural, social economic and enabling environment at the various ANC facilities that would encourage men to participate in ANC service.

Keywords: *Antenatal care, maternal health, morbidity, mortality*

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LIST OF ABBREVIATIONS

ANC	Antenatal care
ARV	Antiretroviral drugs
FP	Family planning
ICPD	International Conference on Population and Development
IPT	Intermittent Preventive Treatment for malaria during pregnancy
PMTCT	Prevention of Mother-to-Child Transmission of HIV/AIDS
PNC	Post Natal Care
RH	Reproductive Health
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
UNICEF	United Nations International Children Emergency Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Antenatal care (ANC) services given by skilled health care professionals is important for monitoring pregnancy, thereby reducing potential health risks to the mother and child during pregnancy and delivery (WHO, 2015). While ANC attendance varies between developed and undeveloped countries, there is common understanding that ANC attendance is a lifesaving intervention for pregnant women and child (WHO, 2015). ANC provides the opportunity to diagnose and treat complications during pregnancy and to provide preventive health services such as tetanus vaccination, prophylactic treatment of worms and malaria, and HIV couple counselling and testing to women and her partner leading to Prevention of Mother to Child HIV Transmission (PMTCT) (Natai et al 2020, &Saly J, 2017).

Globally, maternal morbidity and mortality reduction is acknowledged as essential public health priority (Say et al., 2014). The World Health Organization (WHO) in 2015 estimated about 830 women die each day from complications related to pregnancy and childbirth around the world, and that 99% of all maternal deaths happen in low-income countries and most could have been prevented (Alkema et al., 2016).

Male participation in maternal, child and newborn health as well as other sexual and reproductive health services in Africa has been associated with improvement of maternal and child health outcomes (Chibwae et al, 2018). In many Sub-Saharan

African countries where maternal and newborn mortality are high, women are not regarded as the main decision makers. Men are traditionally reorganized as the heads of families and have a strong influence in decision making in matters concerning to the use of women and children health services (Yargawa et al, 2015).

The establishment of the need to include men in maternal and child health care was as a result of the 1994 International Conference on Population and Development (ICPD) which was held in Cairo, Egypt, which urged that efforts special to encourage men's shared responsibility and emphasize their activeness in participating in ANC, responsible parenthood; sexual and reproductive health behaviors including family planning; and antenatal, maternal and child health (United Nations, 1995).

According to 2016 annual report of Uganda Martyrs" Hospital – Ibanda, half (50%) of the women attending ANC did not have an attendant who accompanied them and a few who had them rarely had attendants as their male partner (Kiwanuka, 2015). This reveals them evidence that few men are involved in caring their women during ANC. In neighboring country of Kenya, poor utilization of facility based antenatal care and maternal services was notably hampering reduction of maternal morbidity and mortality rate (Kwambai et al, 2013). In response to poor male involvement in ANC, Tanzania officially launched a male involvement strategy in 1994 with the intention of including men in all aspects of a reproductive and child health (MoHSW, 2014).

Despite efforts against reduction of maternal death, Tanzania still bears a burden of many maternal mortality, approximated at 556 per 100,000 live births (TDHS, 2016).

As a result of this rate, there is increased need in promoting several interventions to reverse the current trend of maternal mortality. One of such interventions is encourage activeness of male participation in antenatal care and encouraging their pregnant women to utilize existing reproductive health care services, which is crucial, owing to the well-known positive impacts of women's health-seeking behaviors on maternal, child and neonatal health outcomes. (Alemi et al, 2015).

Men are encouraged to participate actively in ANC by health care practitioners, in part because men in most cultures have a strong influence over most family decisions, particularly those involving their family members' health. Men make all of the decisions on when, how, and where women and children get health care. Men's roles as decision-makers and providers in their households have an impact on this. This has long-term implications for children's and women's health-seeking behavior, as it encourages enhanced early treatments that lead to better maternal health and the avoidance of pregnancy problems (Saly ,2017).

Men participation in antenatal care requires a process of behavioral and societal changes to encourage men to play more responsibilities in reproductive and child health. Men's behaviors, attitude and, their beliefs have impact on the reproductive, maternal and child health. Poor men participation in reproductive health services could lead to reduced number of women who seek health services and utilization of health facility services for delivery, as a result that can worsen maternal and child health outcomes. Male participation in ANC is an opportunity for reproductive health policy makers and health service delivery (Naomi, 2005).

The 2015 WHO Recommendations on Health Promotion Interventions for Maternal and Newborn Health focused on interventions to promote active involvement of men during antenatal, childbirth and postnatal, to facilitate and support improved maternal and child health outcomes. The interventions are recommended on the situation that women's choices and their autonomy in making decisions are respected (WHO, 2015). Programs planners and policymakers of ANC services have a major role to play on the health of women and children, as well as the success of male involvement programs, because men are underrepresented in maternal health promotion, prevention, and care programs (Greene, et al. 2002).

The poor participation of men in maternal health promotion, prevention and care programs by program planners, policy makers, and implementers of maternal health services has had a serious impact on the health of women and children, and the success of programs (Greene, et al. 2002).

As much as men may be willing to actively take part in ANC, other factors can contribute to their low involvement (Naomi W,2015 & Saly J, 2017). Addressing these could strongly improve men's participation in ANC. This would encourage men to support their partners to prepare for delivery, and seek out appropriate health care where necessary (Sigh, 2006). Several measures had been undertaken to improve male involvement in ANC although the factors responsible for the poor male involvement in ANC are unknown. We conduct this study to establish the barriers to male partner participation in ANC in Nyamagana district, Tanzania.

1.2 Problem Statement

The Tanzania health sector stresses the need for the active participation of men in reproductive health care to improve maternal and child health outcomes. The Tanzania Health Sector Strategic plan 2015–2020 (HSSP IV) and The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015 highlight the responsibility of men in supporting their partners to improve their demand and access to quality health services (MoHCDEC,2015). Despite the benefits of involving men in improving maternal health outcomes, the rate is too low that indicates existence of some barriers that hinders male participation. (Alemi et al, 2015).

In Mwanza region the use of maternal and child health services is low compared with that of national level according to Tanzania Demographic and Health Survey (TDHS) (2015–2016) it was reported that 47.6% women have four or more ANC visits, and use of skilled birth attendants (SBAs) during delivery is 54%. Male partner participation is 54.4% which is less than the national target of 90% (Natai et al, 2020), and Western and Lake Victoria Zone regions of Tanzania have been identified as areas with unacceptably high neonatal and maternal mortalities (Michael, 2012). Without improving rates of male partner engagement, improvement in maternal and child outcomes would be limited (Singh *et al.*, 2003; MoHSW, 2014).

In response to poor male involvement in ANC, several measures have been made to improve the situation: Tanzania officially launched a male involvement strategy in 1994 with the intention of including men in all aspects of a reproductive and child

health, sensitization and health promotion to raise the awareness however the male participation is still poor (MoHSW, 2014).

In Nyamagana district women have low utilization of antenatal care services. Where WHO and Tanzania national guideline recommend at least four ANC visits, in 2016 only 51% had four ANC visits and only 24% of women made their first ANC attendance before the twelve weeks of pregnancy which suggest that men could also had poor participation in ANC services (TDHS-MIS, 2016).

Nyamagana District was purposively selected because as the maternal mortality in Mwanza Region approach at 305 per 100,000 live births and the proportion of mothers who give at home without skilled birth attendants stands at 54% of all births in the region, which is higher than the national rate of 50% (Nkyya E and Kohi TW,2021) Generally, Nyamagana District itself among all seven districts of Mwanza region has a relatively highest maternal mortality of 42% (Nkyya E and Kohi TW,2021).However, there is limited specific studies and information regarding of male involvement in ANC in Nyamagana district.

Therefore, a researcher is conducting formal investigation into the barriers to male involvement in ANC in Nyamagana district, Mwanza Tanzania in a bid to put in place measures to enhance male involvement in ANC and reduce challenges associated with poor male involvement in ANC.

1.3 Research Objectives

1.3.1 General Objective

To explore the barriers to Male involvement in ANC in Nyamagana district, Tanzania.

1.3.2 Specific Objectives

i) To determine the social-cultural factors influencing men participation in ANC

ii) To determine the economic factors influencing men participation in ANC

iii) To assess the health-facility factors influencing male involvement in ANC.

1.4 Research questions

i) How does socio-cultural factors affect men participation in antenatal care in Nyamagana district?

ii) How does economic factors affect men participation in ANC?

iii) How does health services in Nyamagana district affect men participation in ANC?

1.5 Significance of Study

Effective prenatal care is facilitated when both husbands and wives have positive attitude towards participatory health services. The failure to involve men in antenatal care programs implies a failure to assess the potential existing antenatal care services in health facilities such as HIV testing, family planning and health education (Saly, 2017)

According to the study that was done in Mwanza city to find out the prevalence of male involvement in antenatal care found that only 54.4% are participating in this

services which is less than the national target which is 90% (Natai CC, 2020). Decisions about health services utilization and childbearing may be confounded by unequal power relations, especially in a patriarchal society as in the Nyamagana community which emphasizes on male dominance in the culture. The Sukuma culture accords great value to the males as the sole decision makers.

Although Tanzania is increasing efforts to improve the quality of health services especially maternal and reproductive health, the reality of male involvement in the antenatal care services in Tanzania is less documented (MoHSW, 2014). This study highlights the need for deepened commitment to understanding the factors that hinders male partner from participating the antenatal care services in order to ensure that practical challenges are adequately addressed.

Participation of male partners in antenatal care services reduces the burden on the healthcare systems by lowering the prevalence of complications and deaths linked to maternal death. Few research on male partner participation in antenatal care have been conducted to far amongst male partners of Nyamagana district in Mwanza Tanzania. The findings and recommendations from the study will be used to inform and develop strategies that would increase male partner involvement in antenatal care amongst male partners of Nyamagana.

This study will help women to understand how to engage their partners in ANC in orders to be supported, and by understanding the factors that influence male involvement men will be encouraged to find possible solutions to combat those

challenges. This study will help the policy makers in planning and designing interventions to promote male involvement in antenatal care.

1.6 Scope of the Study

The study took into account adult male partners aged 18 years and above of age, and currently living with a female partner in the same household whose partner had a child aged two years or below. The study specifically focused on the subject scope that is, assessing the factors influencing male involvement in antenatal care services in Nyamagana district.

1.7 Delimitations of Study

One of the anticipations was inadequacy of reference data specific for the area. However, references were made to studies conducted in Mwanza city, Magu district which is neighboring district of Nyamagana and in other areas.

The researcher anticipated some inaccuracy data from responders who may believe that the questionnaires are taking up too much of their time or who are unwilling to reveal personal information. Furthermore, the study's geographical scope, limited money resources, and time constraints limited the number of respondents who could be contacted.

The mitigation of the limitations was done by ensuring adequate sample selection, piloting, and rigorous examination of the perceived measurement parameters in the data tool, population, and sample. With the ultimate goal of lowering budget and time

limitations, questionnaire and interview were used to enable the researcher obtain the most important information from the respondents. In order to enhance the practice, the researcher highlighted the need of providing accurate information.

1.8 Organization of the Study

This research was covered in five chapters. Chapter one gives information on the introduction of the study. In chapter one, the following information were covered; the background of the study; problem statement; study objectives; research questions; limitations and delimitations to the study; and definitions to terms used in the study. Chapter two discussed the literature review from previous studies and some empirical evidence based on the concerns and objectives of the study. This chapter also provided a summary of the literature and knowledge gaps, the conceptual framework of the study. Chapter three discussed a description to the methodology that were used in this study. This information include description of; research design; target population; sample size, sampling procedures; data collection procedure; validity and reliability of the data collection instruments and data analysis techniques.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

This chapter describe the review of related study literatures. Previous studies that were conducted on men participation in ANC were reviewed to identify the gaps that exist and which this study is trying to address.

2.2 Definitions of significant terms

Male Involvement/Participation - Men's Participation is defined as men attending ANC services with their partners, knowing their partner's antenatal appointment, discussing antenatal interventions with their partners, sup-porting their partner's antenatal visit financially, taking time to find out what goes on in the antenatal clinic and seeking permission to use a condom during the current pregnancy (Byamugisha et al, 2010)

Antenatal Care - Is a type of preventive care which refers to the routine medical and nursing care recommended for women during pregnancy with the goal of providing regular check-ups that allow health care providers to diagnose, treat and prevent potential health problems during pregnancy while promoting healthy lifestyles that benefit both mother and child. (Byamugisha et al, 2010)

Antenatal clinic - A place where consultation and antenatal profiles (blood tests and urinalysis etc.) are done by a health care provider (Saly,2017).

Family planning – Making choice for the number of children in a family and the time between one birth and next (Natai et al, 2020)

Postpartum (postnatal) period –Immediate period after child birth and extending to six weeks (WHO,2015)

2.3 Theory to Guide the Study

Is a well-tested theory available to understand the mechanisms of Social and Behavior Change (SBC), with a common denominator being the conceptualization that people engage in an internal decision-making process, weighing the pros and cons of taking a specific action, in this case, men participation in ANC (Rosenstock IM, 2004).This study uses the Health Belief Model(HBM) as a theoretical framework to explore the barriers to men making decision to participate in ANC, and more importantly to investigate the social cultural, economic and health facility reasons behind poor male participation in ANC. The major premise of this model is that existing beliefs can predict future behaviors (Rosenstock IM, 2004). According to Rosenstock and Becker, when applied to health seeking behavior, the Health Belief Model suggests that one's willingness to seek health services or care combined with their expectations of a particular action (such as men accompanying their partner to ANC clinic) can serve as a predictor for future outcomes (in this case improvement of maternal and newborn health).

Health Belief Model includes five major constructs, namely: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues

to action (Rosenstock IM, 2004). Perceived susceptibility refers to an individual's belief about the likelihood of acquiring a disease. Perceived severity refers to the individual's feelings of the severity of such illness (Jones C et al,2015). The perceived benefits construct is related to one's perception of the usefulness of a particular health behavior, in this case, the benefits of male involvement in antenatal care. According to (Jones C et al,2015) Perceived barriers correspond to the individual's assessment of obstacles that could prevent them from performing the health behavior (in this case are social-cultural factors such as age and marital status, education, profession, cultural Issues, economic factors such as financial constraints and health service related factors such as behavior and language use by health workers, venue and space constraints, waiting time, quality of care and gender distribution of the staff in health facilities. (Vyonne, 2020)

Lastly, cues to action refer to the cues that stimulate an individual to adopt a or reject a specific behavior Examples of internal cues to action within the realm of male involvement in ANC could include previously male witnessing or experiencing harsh language and rude action from health workers during antenatal care, while external cues could include reading a story about exposure of somebody HIV positive test in the newspaper or viewing other client information while in antenatal clinic or visited a clinic and found no space to accommodate men (Rosenstock et al, 2004, Andrea,2014).The addition of self-efficacy to the HBM in suggests that if an individual does not feel confident in pursuing an action for example a man to accompany his wife to the ANC clinic, or does not feel that is effective action in preventing reduction of maternal morbidity and mortality,

they are unlikely to pursue behavior changes.

2.4 Barriers to Men Participation in the ANC

2.4.1 Social and Cultural Barriers

Sociologists have made significance progress to shade light on the basic social and cultural structure and processes that impact health. Social and cultural factors have influence on health by affecting vulnerability or exposure to infections and diseases, risk-taking behaviors, the health promotion effectiveness efforts and access to quality of health care. Social and cultural factors also contribute a significant role in improving perceptions of and responses to health problems and the impact of poor health on individuals' lives and well-being (Byamugisha et al 2010). In addition, such factors pray a role to understanding societal, community and population processes such as current and changing rates of morbidity, mortality and survival. (National institute of health, 2014)

According to review of literatures in different studies, the following factors were referred as the barriers to men involvement in ANC.

2.4.1.1 Education

According to a study conducted in Uganda, male partners with higher education were twice as likely to participate in ANC than those with less education (Kakaile, 2017). A study in Kinshasa found that the level of education of pregnant mothers or their partners had no impact on men involvement in ANC (Ditekemena et al, 2010)

2.4.1.2 Age and Marital Status

Several studies revealed that age and marital status were linked with men participation in antenatal care services. A study conducted by Diketemena et al in Kinshasa found men participation was 1.2 times higher among male partners whose female partners were 25 years or older (Ditekemena et al, 2010). Monogamous partners and cohabiting men were twice and 1.6 times respectively more likely to be involved (Ditekemena et al, 2010). In contrast, Nkuoh et al reported that Cameroonian men in polygamous relationships showed higher involvement.

2.4.1.3 Profession

One of the study that was conducted in Rwanda demonstrated that male partners with a well-paid profession were more likely to involve in PMTCT services compared to those who are not well paid. In Uganda, bodaboda (motorbike riders) and taxi drivers were less likely to involve in antenatal care compared with other occupations such as farmers, peasants or constructers (Byamugisha et al, 2010). Reece et al. revealed that Kenyan husbands with only an temporary jobs are less likely to involve in ANC services.

2.4.1.4 Culture

In various studies gender and cultural norms were reported as barriers for men participation in antenatal care services. It was reported that men have poor perceptions on ANC attendance with their spouses. One of the study which was conducted in Kyela Tanzania reported the perception that men who escorted their women to ANC clinic

as being controlled by their partners or were mocked by their peers (Elizabeth et al, 2019). Some men perceive that ANC services are reserved for only pregnant women, thus are embarrassed to find themselves in such “female” places (Elizabeth et al, 2019). Some women too, dislike to be seen being accompanied with their husbands. One of a study conducted in Kenya reported that some men trust traditional healers but not health centers and therefore do not like to attend ANC clinics (Sally,2017).

2.4.1.5 Male Attitudes and Beliefs

Fear of testing HIV and getting positive result and concerns of privacy and confidentiality are barriers for men to attend ANC. In several studies male partners were reported as being strongly concerned about HIV related stigma and result disclosure. Some men may be afraid of HIV positive result disclosing in health facilities, where there is weak health system (Reece et al. 2010). In other study reported, fearing to engage their husbands in PMTCT if men were didn't know their HIV status, refused to be tested, or were in denial about it (Reece et al. 2010). Some men assume that if their partners have already been tested, there is no need for them to be tested because the results will be the same (Falnes et al. 2011).

2.4.1.6 Female Attitudes and Considerations

Women who are gender-based abuse victims may be scared to ask their partners to involve in antenatal care, family planning and HIV testing (Karamagi et al, 2006). According to several research, some women who attend antenatal clinics fear violence from their partners who also attend the clinics with them (Medley et al. 2004). These women are afraid of how their husbands could respond after the discovering HIV

positive result that may contribute to more violence, abandonment, lack of financial support, stigma, discrimination, abuse to family members, and even divorce (Medley et al. 2004).

2.4.1.7 Alcohol Use

Alcoholism usage was reported as a barrier for men not involving in antenatal care. Daily intake of alcohol by male partners maybe catalytic agent for physical violence towards women. Alcohol is reported as one of reasons 54% of marriage violence and 14% of physical assort in Uganda (Karamagi, 2006).

2.4.1.8 Communication

In one the study that was conducted in Western Kenya show that there was association of poor communication among partners and low male participation. (Reece et al. 2010). Good couple communication, on the other hand, was linked to high seropositive status disclosure and support among men and women. For example, the emphasis of men's participation in antenatal care in that study was on their willingness to assist their wives in PMTCT activities such as counselling and testing, antiretroviral prophylaxis medications, and feeding options (Kakaile, 2017).

Male participation in antenatal care improves communication between spouses about risk sex and changes in behavior (Desgrees et al. 2009a). This is particularly important in discordant couple, where men's participation in counselling and testing can help the couples in addressing condom usage, reduce sex with outside partners, and thus avoid STI transmission to the uninfected partner (Allen et al. 2003: Roth et al. 2001). Good

communication has also been linked to the use of contraception (Kakaile, 2017).

2.4.2 Economic Barriers

2.4.2.1 Financial Constraints

Client and health-care facility financial constraints have been described as a barrier to health-care use and male involvement. According to a Tanzania report, some health providers ask clients to be bribed to cover their financial deficits, and other researcher have described low health provider wages as a determinant of men participation in ANC (Elizabeth,2019)

The distance that male partners must travel to clinics for participation in health education, blood tests, and treatment, as well as the costs of transportation to the clinics and the amount of time per appointment at the clinic, were established as barriers to male involvement in a qualitative study conducted in western Kenya by Reece (Reece et al. 2010). Men were unable to participate in ANC due to lack of access or logistical issues. Men discussed their perceptions of their primary roles as providers. As a result, time spent at clinics and away from jobs or other sources of income was clearly seen as an obstacle to their participation in the ANC program. The distance, as well as the cost of transportation and the clinic operation working hours were also mentioned with some frequency (Reece et al. 2010).

According to data from another research from Uganda about factors influencing male involvement in reproductive health, the majority of participants said that health facilities were few and far away from the people, health services like treatment and

testing are not available (Kakaile, 2017). The majority of male spouses and men in general preferred that health programs be implemented and extended to their villages or near to their homes to save them time and money (Kakaile, 2017).

2.4.3 Health Services Related Barriers

2.4.3.1 Behavior and Harsh Language Use

According to Byamugisha et al, health providers harsh and critical language to Ugandan women was a barrier to male participation. Men were discouraged from returning or engaging in antenatal activities due to the harsh treatment they received from health care providers (Byamugisha et al. 2010). Men were also denied admission to some clinics by some providers. Staff members' lack of common courtesy, their rough treatment of pregnant women, and health-care workers refusing to let men into the antenatal clinic with their partners were all stated by men (Byamugisha et al. 2010),

Men reported feeling unwelcomed and disrespected by healthcare workers who were reluctant to promote male participation in antenatal care at all, and that it was apparent that facilities infrastructures were designed without their specific needs in mind. Another obstacle listed was the charging of unofficial user fees, as well as the lack of integration of facilities, which discouraged men from getting checked because they feared their information would be exposed (Larsson et al. 2010).

2.4.3.2 Venue and Space Constraints

Men were invited for free voluntary counselling and testing (VCT) in three venues: a bar, a health center, or a church, in one of the studies in the Democratic Republic of

Congo. Male participation in VCT was higher in the bar (26.4%) and the church (20.8%) than in the health center (18.2%) (Ditekemena et al, 2010). These findings indicate that more friendly, welcoming and convenient venues for men are needed. Male participation has also been stated to be hindered by a shortage of room in ANC clinics to accommodate male partners. Due to a shortage of space, clinics are often not able to accommodate women and their husbands at the same time (Ditekemena et al, 2010). For increasing male participation, targeted approaches such as personalized messages, special health education sessions, and creative ways to identify male-friendly venues will be beneficial.

2.4.3.3 Waiting Time

Due to burden of some administrative processes, women often have to wait a long time for ANC services, resulting in inadequate patient/client care at health facilities. Men in the daily pay labour such as boda boda, bus assistant known as kondakta are often unable to devote nearly the whole day to ANC services (Byamugisha et al, 2010).

2.4.3.4 Quality of Care

A study in Rwanda about Determinants of nonadherence to a single-dose nevirapine regimen for the prevention of mother-to-child HIV transmission found that health providers often failed to provide standard services, leading to low ARV prophylaxis uptake among clients and bad appointment scheduling (Delvaux et al, 2009). Health-care workers are often overworked, exhausted, and they work in a situation of restricted resources. In such a situation, quality of services, and caring for participating male partners is seen as an additional burden (Delvaux et al, 2009).

2.4.3.5 Time of Day for Providing ANC Services

A study that was conducted in Kinshasa about factors influencing male involvement in ANC reported that when reproductive clinics are open in the evening between 5:00 and 8:00 pm and on weekends in Kinshasa, male participation in the antenatal services increases (Ditekemena et al, 2010). The ANC services are usually only available on Monday-Friday in mornings, when the majority of men are at work. ANC opening hours, on the other hand, have been reported as a limiting factor for male participation in ANC services (Nkuoh et al, 2010). Geographical limitations have an effect on the use of health services and male involvement (Bwambale et al, 2008). Low health service use and insufficient male participation can be attributed to a lack of decentralized services (Bwambale et al, 2008).

2.4.3.6 Dominance by Female Staff

Men could be limited by the fact that most ANC facilities are dominated by female health workers and patients. Positive men form support groups at male health centers, where both active and non-active men are counseled on the advantages of accompanying their spouses to antenatal appointments. Men are often educated on topics that are generally taboo for men, such as the value of exclusive breastfeeding for mothers who are seropositive (Byamugisha et al,2010)

2.5 Policy Review

2.5.1 The 2017 Tanzania Health Policy

The 2017 Tanzania health policy addressed the priority areas towards achievement of sustainable development by 2030 among which is Reproductive health. The 2030

Sustainable Development agenda contains a number of targets related to sexual, maternal and reproductive health. Specifically, target for ensuring men and women access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030 (National Health Policy,2017). Likewise, target for ensuring universal access to sexual and reproductive health and reproductive rights. Other targets in the 2030 Agenda related to reproductive health in this policy include reducing the maternal mortality ratio to less than 140 per 100,000 live births; ending preventable deaths of newborns and children under 5 years of age ; and eliminating all harmful practices, such as child, early and forced marriage and female genital mutilation (National Health Policy,2017).

Meeting the targets related to reproductive health can be highly achieved if men are actively and positively engaged from antenatal, child birth and postnatal. Engaging men in these efforts ensures both men and men understand the importance of collaboration in SRH and child birth.

The strength of this policy is addressing the issue of gender sensitive which influence male involvement in antenatal care and antenatal care so far.

However, the policy does not clearly state the strategies which could be used to promote and encourage men participation in reproductive health which is still a challenging in the reduction of maternal mortality target in Tanzania.

2.6 Conceptual Framework

A conceptual framework, is a set of broad ideas and concepts drawn from specific fields of inquiry and used to organize a subsequent presentation (Vyonne et al,2020). It's a study tool that helps an investigator gain a better knowledge of the situations they're looking at. In order to achieve the research's goal, the framework used the conceptual structure illustrated below. Male participation in antenatal care was described as being hindered by factors such as health-care services, socio-cultural factors and economic factors.

The conceptual framework of men participation in ANC for this was adapted from Yvonne (Yvonne et al,2020). In the adapted model, a men participation in ANC is influenced by his social-cultural characters including age, educational status, occupations and cultural issues. The level of male involvement can also be influenced by their marital status and living arrangements.

Men can be unable to participate in activities that are considered feminine due to culture which separate gender roles. Men maybe unable to get involved because other family member, such as mother and mother-inlaw, who perceived as the one responsible for issues of pregnant and deliveries. Some taboos can prohibit men from participating in certain aspects of maternity care.

Economic barriers such as transport cost, service fees and poor income may also be source of poor male participation in ANC.

Male participation in antenatal care may or may not be influenced by issues related to

health facilities. Male involvement could be limited if health facilities are not prepared to accommodating male partners who are accompanying their spouses. Men friendly service could also be a factor. The model is relevant to the study because its basic argument clearly explains the current study's objectives of investigation about perceptions regarding determinants of men participation in ANC in Nyamagana district.

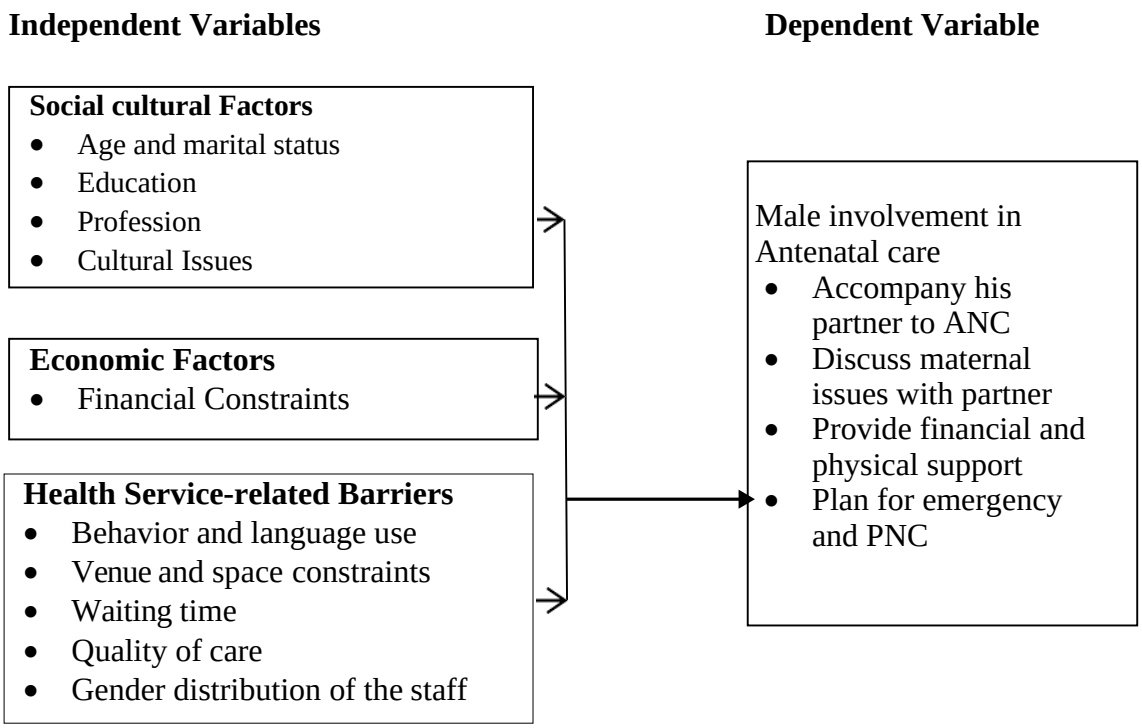

Figure 2.1: Conceptual framework on barriers to men participation ANC

Adapted from Yvonne (Yvonne et al,2020)

2.7 Summary of the Literature Review

One of the gaps found when reviewing the previous research is persuading male participation in ANC with their partners. All independent variables are thought to have an effect on the dependent variable, and the studies' results would be either positive or

negative. Review of literatures is essential for all study projects due to reason that it provides guidance and examples of comparisons for the researcher. As a result, it was important for the researcher to go through all of the relevant literature for the study in progress.

More information about men and ANC is focused on HIV tests and other components of PMTCT. More studies are required on how to include male partners antenatal clinic and other services such as family planning, immunization, and so on. Men's involve in birth-preparation, promoting facility delivery, and reduction of spread of HIV There is insufficient studies on the importance of regular syphilis testing at ANC clinic by involving male and pregnant and the possible impact of STI testing on promoting male partner screening coverage.

Male partners depend woman as representative for his own screening which indicate limitation in male understanding of the dynamic of spread of HIV and couple-discordant. The most available information on male involvement in ANC are provide by women and lessons learnt from male attending ANC. There is limited data on male and couple who didn’t use the ANC service.

2.8 Knowledge Gap

It would be beneficial to conduct studies on the differences among the couple who utilize ANC services and couples who don’t utilize the services. What's the relation between couple services, utilization, and male participation? Is couple confounding factor in the relationship between use and health or behavioral outcomes? These are

some of the questions the researcher believe are needed to be answered, and it is likely by conducting another study would find out the results.

Most of the other studies related to this one used mostly qualitative methods (Natai C,2020) and some used a mixture of qualitative and quantitative methods but without using any models (Ongolly F et al,2019) and purely quantitative method like that of (Alemi et al,2015). This gap was filled as this research involved a combination of both qualitative and quantitative methods including the use of logistic regression model in order to get a touch of both qualitative and quantitative facts.

Most similar studies about male involvement in ANC used men respondents only like of (Alfred et al,2018 and Sumitra et al, 2021) or used only female respondents (Vyonne et al,2021. This study intended to fill this gap by obtaining information from both male and female regarding social, economic and cultural and health facility factors influencing male participation in antenatal care.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Chapter Overview

Chapter three tells how the study was conducted. It describes how the research was designed, the targeted population of the study, sample and sampling procedure, data collection tools and process as well as data analysis.

3.2 Research Design

A cross-sectional research design is used in this study. This design is suitable for a study in which a particular population is sampled at a single point in time (Sally 2017). The design allows for data collection in a natural setting, which is both quicker and less expensive, and the findings are easily extrapolated to a wider population. Its application allows to collect both qualitative and quantitative data at ANC clinic. A descriptive survey study asks people about their perceptions, attitudes, behaviors, and values in order to gather data that explains current phenomena. The descriptive approach also allows basic statistics, tables, charts, mean scores, percentages, and frequency distributions to be used to present the study results (Mugenda & Mugenda, 2003). The research examined male participation in antenatal clinics, including beliefs, behaviors, values, challenges, and suggestions.

3.3 Study Area

This study was conducted in Nyamagana district which is one of the eight districts in Mwanza Region. The below is the social economic profile of Nyamagana distric council:

3.3.1 Geographical Location

It is bordered to the north by Misungwi district, Magu to the east district, Lake Victoria to the west and to the south by Ilemela district (Wikipedia)

3.3.2 Administrative Area and Population

The district comprises of eleven wards and one division. As of 2012, the population of the Nyamagana district was 363,452. (National Bureau of Statistics, 2013

3.3.3 Education

The district has thirty-nine secondary schools. Among those, twenty-eight are government owned and eleven are private secondary schools, four colleges and one University (Suzana, 2014).

3.3.4 Health Care

It has 4 hospitals, 7 health centers, 17 dispensaries, 4 maternity homes, and 7 private clinics (Ennegrace, 2021). In 2015, among the causes of mortality for inpatients of all ages was severe malaria (38.3 percent) followed by pneumonia (22.6 percent), other diagnosis (11.5 percent), anemia (8.3 percent) and normal delivery (7.7 percent). Other diseases were tuberculosis, acute respiratory infection and burns (Ministry of Finance & NBS, 2017)

3.3.5 Economic Activities

The main activities of Nyamagana district are fishing, farming, livestock keeping, manufacturing, trade and commerce, services such hotels and lordge. Currently, an urbanization process transformed the extensive Irrigation system to simple irrigation

along the lake shores and some inland areas. Irrigation is mostly used in vegetable, fruits and maize production. The main area where agriculture is practiced is Kishili ward (Ministry of Finance & NBS, 2017)

3.3.6 Ethnic Groups

The major ethnic groups are Sukuma, zinza, kerewe, Kara, haya and kurya, though are other minority ethnic groups such as Nyamwezi, Arabs, Hindi and other Asians which they speak their native languages along with Swahili (Ministry of Finance & NBS, 2017).

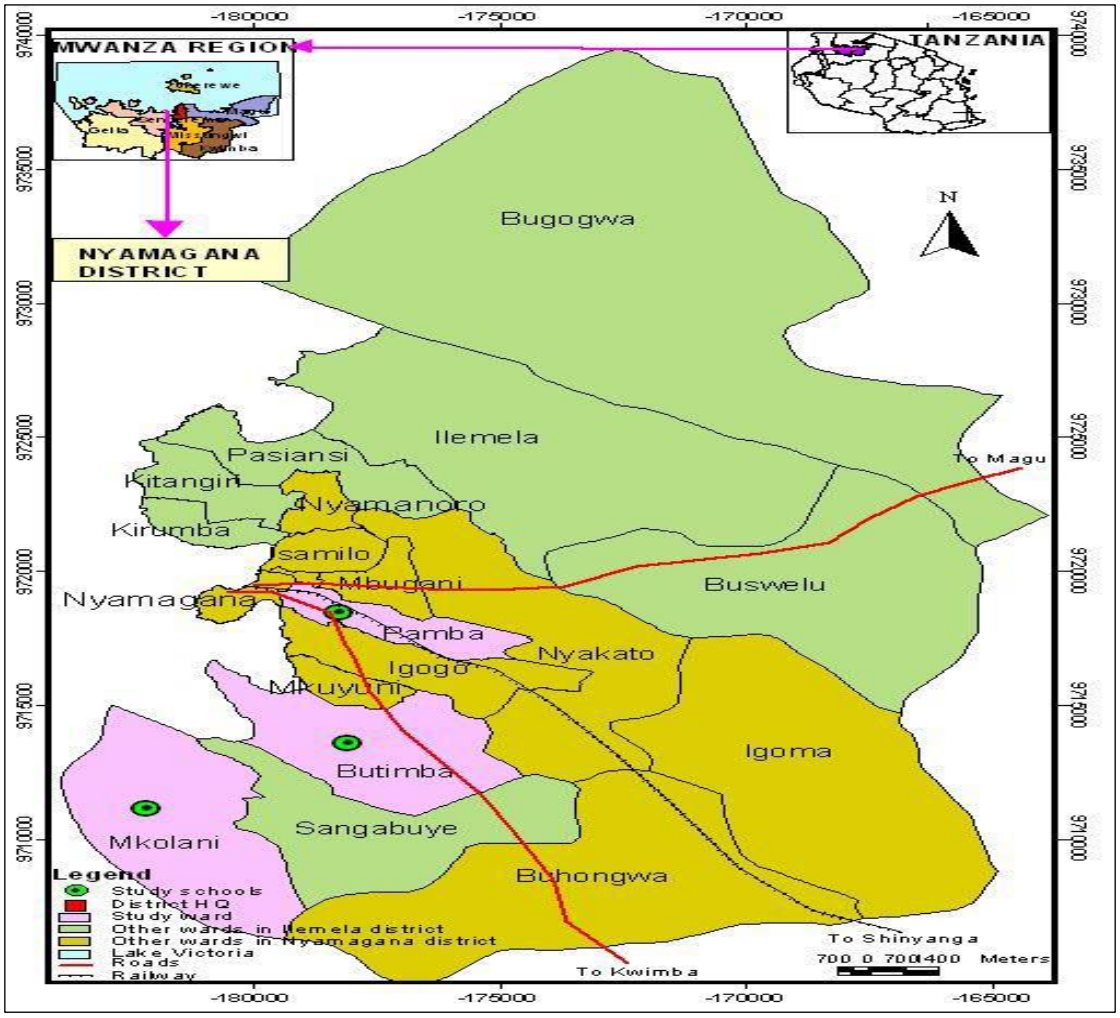

Figure 3.1: Map of Nyamagana District showing the study area

(Source NBS, 2012)

3.4 Study Population

Study population is a set of people, services, elements, and events, group of things or households that are being investigated. As per the purpose of this research, study population are men (18-60 years) with a partner with a child born within two years.

3.5 Sample Size

3.5.1 Sample Size Estimation

The sample size was obtained using the Kish Leslie's formula (Kish L, 1965) as shown below.

$$\mathrm{N} = \frac{t^2 \times p\,(1-p)}{m^2}$$

Where by:

N = required sample size, t = confidence level at 95% (standard value of 1.96), p = estimated prevalence of men attendance at ANC which was 20.4% from previous study in Magu district (Vermeulen E et al,2016). m = margin of error at 5% (standard value of 0.05) and the sample size is 249 respondents.

3.6 Sampling Techniques

Purposive sampling technique was used to select the sample of respondents basing on the knowledge, place of residence and willing to participate in the study. Purposive sampling starts with a purpose in mind and the sample is thus selected to include people of interest and exclude those who do not suit the purpose (Creswell, 2014). The purposive sampling technique suit the demands of this study as it assures economical aspects in selection of the intended respondents who are eligible and willing to take part in the study.

With the help of ward executive officers (WEO), a list of all wards in the district was obtained. The list of villages was used as the master frame from which 6 villages were purposely selected for the study 2 from rural, 2 from semi urban and 2 from urban to ensure good representation. Selection of respondents involved random selection of households in each selected village where by eligible men present in the household at the time of the visit that consented to participate were interviewed until we reached the sample size.

On qualitative part, 4 groups in two main categories at Makongoro health center of Nyamagana district were selected. First category was two groups consisting of pregnant women with more than three ANC visits, the second category of two groups consisted of postanatal women who delivered within 12 months' prior the day of conducting interview. Each group formed by 6-8 women for focused group discussion (FGDs). Total four groups gave their opinions on the perceived factors influencing male participation in ANC.

3.7 Data Collection Methods

The data collections began in 6th June, 2021, and completed in the beginning July 2021. Researcher and Research assistants visited participants at their households with the guidance of Village leader. The study used primary data as main source of information. The data collected at the field with structured interviews and focus groups discussions (FDGs).

3.7.1 Primary Data

In order to get answer of objectives of the study we collected both qualitative and

quantitative data. Semi-structured questionnaire used to gather quantitative data (Appendix II). Focus group discussions (FGDs) with guide of a checklist (Appendix III) was used to gather qualitative data. The combinations of both quantitative and qualitative information were done in order to maintain data triangulation and ensure finding validity.

3.7.1.1 Questionnaire

Semi-structured questionnaire containing both open and closed ended questions were used to interview respondents (Appendix II). (Gass et al 2007) recommend the use of questionnaire, stating that questionnaire do not have to be entirely closed or open ended, but can include a variety of questions based on the study objectives. Respondents were personally visited in their households. To provide for greatest freedom of expression, men were interviewed by a male study assistant.

3.7.1.2 Focus Group Discussion (FGD)

A focus group is, at its most basic level, an informally discussion among a set of individuals about a specific subject (Wilkinson, 2004). Without forcing them into making choices or achieving an agreement, a focus group technique was utilized to investigate and evaluate what people are thinking, how they are thinking, and why they are thinking the way they do about issues involving male involvement in antenatal care. The researcher was guided by a check list (Appendix III) in conducting the discussion.

Four focus group discussions were held at Makongoro Health Center which is the main

RCH center of Nyamagana district, two groups for antenatal women and two for postnatal. A sample of between 6-8 respondents was requested to participate. According to Patton (2002), typically groups of people who participate in the discussion should be composed of six to eight and discussions should last for half an hour to two hours.

There was a facilitator, as well as two trained assistant researchers who were in charge of taking verbal and nonverbal notes, as well as one who was in charge of voice recording. The facilitator assigned respondents numbers to make them feel like they were member of the team and to recognize their contributions.

The role of facilitator was to make participants feel more comfortable, to pose questions, to explore for some more details, and to provide everyone adequate opportunities to speak. In order to attain the perspectives of each respondent, it was necessary to include everybody in the discussion. An investigator and one assistant researcher were writing notes, while another assistant researcher used a tape recorder to record the conversation. This was necessary in order to maintain quality and accuracy during writing a report.

The facilitator moderated a discussion in Kiswahili. She began by explaining the regulations of a focus group then she posed a question. She urged all respondents to air their views and was probing for answers when some participants were hesitant. Each focus group discussion completed between 30 minutes and 1 hour.

3.8 Data analysis Procedures

Quantitative data were coded, tabulated, cleaned, processed and analyzed using statistical package software for the Social Sciences (SPSS) version 25.0. Univariate analysis was used to determine the frequency and percentage of demographic characteristics as well as the barriers to male participation in various ANC activities. A *Chi-square* test was used to see if there were any association between the male participation and other variables. To find out what characteristics influence men's participation in ANC, a researcher used bivariate and multivariate logistic regression analysis. A <0.05 p-value was used as the significance level.

3.8.1 Qualitative Data Analysis

Data from Focused Group Discussions was audio recorded, transcribed, translated (from Kiswahili to English), typed, and revised and edited The information was then organized according to the research questions, categorized and coded into several themes and sub themes relating to determinants of male involvement in antenatal care as per the Conceptual framework (Figure 2.1).

Before grouping the data collected into these themes and their associated sub themes, similarities and discrepancies were resolved. The acquired data were analyzed using a content analysis, in which replies from participants (FGDs) were listed, coded, and eventually categorized. Based on the conceptual framework (Figure 2.1), these data were grouped into themes after being exported to NVivo software version 12.

3.9 Research Ethical Consideration

Approval letter was sought from Open University of Tanzania. Furthermore, the

researcher sought a permission from the District Executive Director (DED) office and a researcher was further networked to community leaders in particular wards of Nyamagana district.

To the study participants, informed consent form provided before the data collection. No names used in order to ensure confidentiality. The purpose and advantages of the study were elaborated to the study respondents. Prior to participating, the respondents were offered the option to have their views represented. Respondents had the option of declining to participate in the study.

3.10 Validity of the Questionnaire

Validity is a degree where the selection of test items represents the subject that the test is supposed to measure, according to (Somekh and Cathy, 2005). According to Mugenda & Mugenda (2003), validity indicates that the study findings appropriately reflect the topic under investigation. They argue that using a specialist or experts in a specific field to determine the material validity of a measure is the standard practice. The researcher sought the opinion of the experienced researchers and performed a pilot study to determine the validity of the study instruments.

3.11 Reliability of the Instrument of the Study

The degree to which research tools consistently produce identical results over a number of similar trials is referred to as reliability (Ngechu, 2004). A pilot study was conducted to assess the consistency and therefore reliability of the responses' correlation. To ensure that the data collection methods are free of unreliability and

misinterpretation, the researcher conducted a test-retest procedure before using the analysis tools to ensure that they are reliable. Initial answers to the questionnaires are expected to aid in re-wording the questions to avoid confusion. Any items that are absent in the questionnaire was added, and the ones that are not appropriate was removed. The aim of the pilot study was to determine the questionnaires' reliability, including the wording, structure, and sequence of questions (Ngechu, 2004).

CHAPTER FOUR

STUDY FINDINGS

4.1 Overview

This chapter presents the findings of the study that was aiming at assessing the barriers of men involvement in ANC in Nyamagana district. The chapter presents the findings from both, FGDs that were conducted to study respondents who participated in the study qualitatively and also the findings from the quantitative study responses. The first part of this chapter shows the socio-demographic characteristics of the respondents and the second part shows the findings on the specific objectives of the study in assessing barriers to men participation in ANC.

4.2 Participants' Social Demographic Characteristics

The total respondents were 201 which is 80.7% of the estimated sample size. The results of the participants' demographic characteristics are shown in Table 1. According to the findings, 41.8% of the participants were between the ages of 18 and 29. Again, the majority of participants (58.7%) were married, while 13.9% were separated or divorced. In terms of educational attainment, 45.3% of participants had completed primary school and 7% had completed university level education. The study also discovered that 78.6% of participants were self-employed. Table 1 also shows that 62.7 percent of participants had 2-4 children and that the majority of them (77.1 percent) lived with their partners.

Table 4.1: Participants' Socio demographic characteristics (n=201)

Variable	Frequency (n)	Percent (%)
Age (Years)		
18-29	84	41.8
30-39	59	29.4
40-49	55	27.4
≥50	3	1.4
Marital status		
Married	118	58.7
Cohabiting	55	27.4
Divorced/ separated	28	13.9
Education level		
No formal education	22	10.9
Primary	91	45.3
Secondary	48	23.9
Diploma	26	12.9
University level	14	7
Occupation		
Not employed	5	2.5
Self employed	158	78.6
Employed in civil/ private sector	38	18.9
Number of children		
1	57	28.4
2-4	126	62.7
≥5	18	9
Living with partner		
No	46	22.9
Yes	155	77.1

4.3 Level of Men Participation in ANC

The study found that 76.3% (n=153) of respondents reported high participation in ANC, while 23.7% (n=48) indicated low participation in ANC (Figure 2).

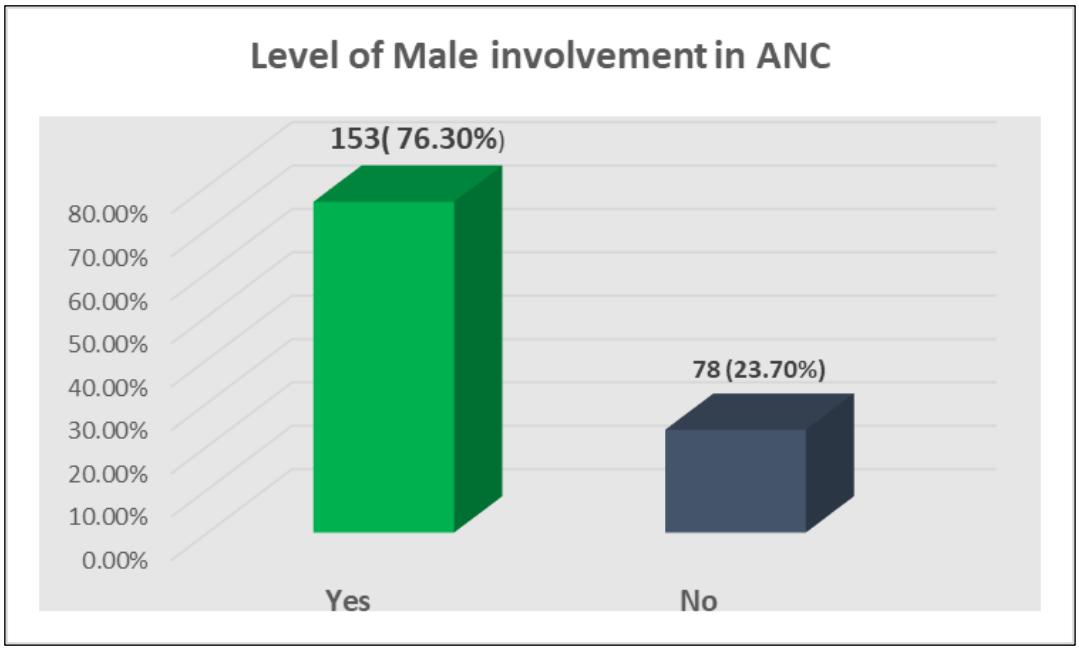

Figure 4.1: Level of men participation in ANC.

4.4 Multivariate Analysis of The Barriers of Men Participation in ANC

4.4.1 Social Demographic Barriers

Table 2 indicates men's perceptions on the social demographic barriers towards their participation in antenatal care. In terms of age, men over 50 years old were less likely to show high participation compared to those aged between 18 and 29 years old (OR= 1.45, 95% CI= [0.37–1.85], p=0.04). When it came to marital status, men who were separated or divorced were less likely to show high participation in ANC compared to married men (OR= 1.36, 95% CI= [0.13–1.87, p=0.02). In terms of living together with partners, men who lived with their spouses were nearly twice as possible to indicate high participation in ANC compared to those who did not (OR =2.15, 95% CI= [1.15–4.02], p=0.01).

Table 4.2 :Social-demographic barriers to men participation in ANC

Variable	Wald	OR	95%CI	P-Value
Age				
18-29	Ref			
30-39	1.57	0.57	0.25–1.36	0.22
40-49	0.63	0.66	0.23–1.75	0.41
≥50	3.06	1.45	0.37–1.85	0.04**
Marital status				
Married	Ref			
Cohabiting	1.17	0.65	0.31–1.37	0.27
Divorced/ separated	4.86	1.36	1.13–1.87	0.02**
Level of education				
No formal education	Ref			
Primary	0.59	1.53	0.49–4.73	0.46
Secondary	0.03	1.07	0.33–3.41	0.8
Diploma	0.05	1.13	0.31–4.27	0.84
University level	1.37	0.38	0.07–1.86	0.23
Employment status				
Not employed	Ref			
Self employed	1.44	0.37	0.07–1.84	0.23
Employed in civil/private sector	0.17	0.71	0.12–3.77	0.67
Number of children				
1	Ref			
2-4	0.05	1.08	0.52–2.25	0.82
≥5	0.41	1.71	0.23–2.04	0.52
Living with partner				
Yes	Ref			
No	5	2.15	1.15–4.02	0.01**

**p < 0.05

4.4.2 Socio Cultural Barriers to Male Participation in ANC

Findings on the men's perception on the cultural barriers to men participation in ANC shown in table 3. The findings indicate that participants who agreed that it is not acceptable for men to carry women's home chores during pregnancy were less likely to show high participation in ANC comparing to respondents who did not agree (OR=1.35, 95% CI= [1.13–1.91], p = 0.004). Again, participants who were agreeing

that men will be perceived as they are ruled by their spouses if they are seen accompanying their partners to the clinic were less likely to report high men participation in ANC (OR = 1.43, 95% CI = [0.21–1.87], p = 0.001).

Table 4.3: Social cultural barriers to men participation in ANC

Variable	Wald	OR	95%CI	P-Value
It is not acceptable for men to carry women's home chores during pregnancy				
No	Ref			
Yes	3.78	1.35	1.13–1.91	0.004**
Men will be perceived as they are ruled by their spouses if they are seen accompanying their partners to the clinic.				
No	Ref			
Yes	4.55	1.43	0.21–1.87	0.001**
Culturally, husbands are not allowed to accompany their partners to ANC clinic				
No	Ref			
Yes	2.22	4.22	0.87–2.2	0.06
Being mocked by friends prohibit men to escort their spouses to the clinic				
No	Ref			
Yes	0.64	1.35	0.63–2.87	0.41
A women can perform her routine duties regardless of her pregnancy				
No	Ref			
Yes	0.12	0.92	0.53–1.52	0.71
**p < 0.05				

4.4.3 Social Economic Barriers to Male Participation in ANC

Table 4 shows findings on the men's perception on the socio-economic barriers to men participation in ANC. The findings show that participants who agreed that having health insurance cover to cater medical care were two times more likely to report high male involvement in ANC compared to whose partners do not have the health insurance (OR =2.23, 95% CI= [2.075–4.561], p=0.001). Again, respondents who agreed to have family motorbike or car were two times more likely to report high male

involvement in ANC compared to who don't own motorbike or car (OR =1.93, 95% CI= [1.091–2.197], p=0.003).

Table 4.4 : Social economic barriers to men participation in ANC

Variable	Wald	OR	95%CI	P-Value
Do you or your partner have insurance cover to cater for your health				
Disagree	Ref			
Agree	3.076	2.23	2.075–4.561	0.001**
Is your monthly income equal or above 100,000 Tsh				
Disagree	Ref			
Agree	0.716	1.31	0.464–1.103	0.131
Does your partner monthly income equal or above 100,000 Tsh				
Disagree	Ref			
Agree	0.802	1.03	0.601–1.756	1.06
Does your household monthly income above or equal to 150,000 Tsh				
Disagree				
Agree	0.611	0.89	0.42–2.13	0.71
Do you have family motorbike or a car				
Disagree				
Agree	2.047	1.93	1.091–2.197	0.003**
Have you/ your partner ever missed ANC clinic due to lack of transport or health service fee				
Disagree				
Agree	0.63	0.33	0.63-2.16	0.51

**p < 0.05

4.4.4 Health facility determinants of men participation in ANC

Table 4 shows findings on the health care facility barriers to men participation in antenatal care. The findings indicate that participants who agree that men have insufficient time to escort their spouses to the ANC in regular visits were less likely to report high participation in ANC (OR=1.62, 95% CI = [1.37–1.97], p = 0.004) Again, men who agreed that health facilities are located to long distance area and that prohibit men to accompany their partners to ANC were less likely to indicate high male

participation in ANC than those who didn't agree (OR =2.11, 95% CI = [1.17–6.36], p =0.001). Finally, participants who responded that male partners are unable to escort their spouses for ANC due to long waiting time spend at the health center were less likely to indicate high participation in ANC than those who didn't agree (OR=1.55, 95% CI = [1.36–1.83], p =0.002).

Table 4.5 : Health facility determinants of male participation in ANC

Variable	Wald	OR	95%CI	P-Value
Men have insufficient time to escort their spouses to the ANC in regular visits				
No	Ref			
Yes	3.21	1.62	1.37–1.97	0.004**
No enough space in ANC clinic for men to be accommodated together with their partners				
No	Ref			
Yes	0.82	1.51	0.62–3.74	0.361
Healthcare costs prohibit men to escort their spouses to the ANC				
No	Ref			
Yes	0.02	0.93	0.42–2.13	0.86
Health facilities are located to long distance area and that prohibit men to accompany their partners to ANC.				
No	Ref			
Yes	2.97	2.11	1.17–6.35	0.001**
Being mocked by health care providers prohibits male partners from accompanying their spouses for ANC				
No	Ref			
Yes	0.33	0.81	0.37–1.67	0.55
Men are hesitant to escort their spouses to the facility for ANC since they are not involved in many things happening at the clinic or assessments of their partners.				
No	Ref			
Yes	0.18	1.22	0.51–2.81	0.68
Male partners are unable to escort their spouses for ANC due to long waiting time spend at the health center.				
No	Ref			
Yes	6.4	1.55	1.36–1.83	0.002**
**p < 0.05				

4.5 Qualitative Assessment Results

4.5.1 Theme 1: Women Perception on Male Involvement in ANC

Women had mixed perception about men escorting their wives at ANC clinic in Nyamagana district. Women would like to be escorted by men in first ANC visit to get tested together for HIV. They also prefer to attend ANC with their husbands in order to make sure that they are received at the clinic get good service from health care workers.

One woman had this statement:

> *"Men has power to command some health workers to provide services on time especially when there is a lot of patients at the clinic or when we meet lazy health workers"* (Nyamagana postnatal women aged 36 years old)

Another woman said

> *"It is essential for couples to get a medical screening because if we develop health problems, we may be addressed as soon as possible to avoid infection to the baby"* (Nyamagana pregnant woman aged 27 years old)

Another respondent said:

> "*It is important to accompanied by husband because there at the clinics, there are instructions that we are given by nurses which the husband also needs to know. It is also important for both of us to get tested to avoid infecting the baby if we are infected*" (Nyamagana postnatal woman aged 34 years old)

However, while pregnant mothers are happy to be escorted by their husbands during regular ANC visits, some of them did not see the advantages of male partners attending regular ANC visits.

> *"Men were supposed to support their partners financially and they were in charge of preparing for paying boda boda to accompany me, no*

> *problem if we don't go together".* (Nyamagana pregnant woman aged 23 years old)

Another respondent added this way:

> "*It is not important for a man to accompany the pregnant women at ANC clinic because that is the duty of the women. Even if he accompanies me there, he will remain outside*" (Nyamagana pregnant woman aged 31 years old)

There was consensus and agreement among all participants that male partners were the main financial supporter and are breadwinners of the household.

4.5.2 Theme 2: Perceived Barriers for Male Participation in Antenatal Care

4.5.2.1 Fear of HIV testing

Participants responded that pregnant mothers and their partners who don't know their HIV status are fearing to go together for antenatal care services. It was reported by various participants that one of the routine services given at the health facility in the first ANC visit is HIV testing. The women reported that, the majority of male partners do not like to test HIV. To them, HIV testing is soliciting more problems.

One respondent said:

> *Men do not like to accompany their spouses to the clinics because they are fear HIV testing. If they are asked about why they don't want to be tested, they say HIV testing is soliciting problems. It is better not to know their HIV status* (Nyamagana postnatal woman aged 31 years old)

Another woman said:

> *"I am comfortable to go to the health center alone during the first visit so that I can understand my HIV status alone, then after it is easy to welcome your husband to attend the second visit so that you get tested together and you act like you don't know your status too"* (Nyamagana pregnant woman aged 34 years old).

Another woman said

> *"Most of us we are not honesty, we are not telling the truth to the researcher the truth is that the only advantage of men to go with the wife is HIV testing, however the room itself is very small and congested, how can a man agree to be tested while other men and women are surrounding the room"* (Nyamagana pregnant woman aged 25 years old).

4.5.2.2 Unfavorable Health Facilities Environment

Respondents revealed that in most health facilities infrastructures are not favorable for men. Ac- cording to participants, in most health centers, several pregnant mothers could be in one antenatal room at once, with no confidentiality, a situation which is not favorable for man to be in the service room and see other women rather than his wife. Therefore, due to inadequate space in the health facilities, male partners are prohibited.

> "*Men are not allowed in the service room. Normally, men stay outside even if you accompanied by your partner, so men get discouraged in the next ANC visit*" (Nyamagana pregnant woman aged 30 years old)

Another respondent added:

> *"Some of men have unofficial sexual relationship with other women a term famously known in Kiswahili language as "nyumba ndogo" or "michepuko", and in health facilities there is no private space to accommodate them, so do you think that man will accompany his partner?"* (Nyamagana postnatal woman aged 22 years old)

Another woman said:

> *"Sometimes when our husbands accompany us to the hospital and are told do not sit here; this place is preserved for only pregnant women. And sometimes the nurse can as him are you pregnant? Do you think that will come again?, surely he will not come"* (Nyamagana postnatal woman aged 27 years old).

CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.1 Chapter Overview

This section highlights the discussion of the study findings that was conducted in Nyamagana districts, Mwanza region. These discussions are centered on the main research objective that was: to assess the barriers of male participation in antenatal care. As a result, the discussion describes the results of the study from participants in relation to the stated objectives. The following discussion is based on the findings of the study's qualitative analysis, which was conducted through focus groups discussion, and the conclusions reached from the study's quantitative analysis, which were based on the Chi-square test.

5.2 Level of Men Participation in ANC

The study examined male partner perceptions of barriers to men participation in ANC in Nyamagana because male involvement has been proved its importance as driving factor to achieve high utilization of maternal and child health services. In Nyamagana, we discovered that male involvement in ANC is high. This is consistent with the results found in the study which was conducted in Kathmandul, Nepal about determinants of male involvement in ANC where men participation level in ANC was high (Bhatta, 2013). Similar results were reported in Ghana by Vyonne et al who found high male participation in ANC (Vyonne et al, 2020). On the other way, the result of this study is opposing the study findings conducted by Craymah et al who reported low male participation in antenatal. In addition, in one of the qualitative study, conducted by

(Secka et al, 2018) also reported low men participation in ANC. Another finding that was contrary reported by Natamu in his study of determinants of poor male engagement in ANC and maternal health care services in Jinja, Uganda, in his study he reported the level of male involvement was low (Natamu D,2011).

The high male participation in ANC in this study could be contributed by Uzazi salama program in the Nyamagana district with objectives to adopt a household-centered design approach, that ensures not only men participation in maternal health services, but also all other members of household, have health information access regarding maternal and child health including ANC (Nattai CC, 2019).

The program was aimed to make sure male partners are involving in all issues regarding to maternal and child health care including antenatal, post-natal care and family planning services (Nattai CC,2019). The high men participation in ANC may also be due to programs such as couple counselling and dissemination of family centered knowledge which target male partners as well as their pregnant women an intervention adopted in order to rise the knowledge and awareness of community members on poor beliefs and perceptions that affect maternal and child health including men participation in ANC in Nyamagana district. This finding could also signify to the existence of a supportive environment that encourages men participation in ANC. This could also be contributed by woman's knowledge sharing, the culture setting, or health-care-related reasons.

5.3 Barriers to men participation in ANC

5.3.1 Socio-Demographic Barrier to Men Participation in ANC

Age of male partners, marital status, and the status of living with a partner are all socio-demographic determinants of men participation in ANC. Individuals' socio-demographic features have a bigger impact on their thinking patterns, preferences, and life choices. A men's biological marital status, age and whether or not he lives together with his partner might all influence his decision to participate in ANC.

The findings of the current study corroborate those of Ditekemena et al., who conducted a study on barriers to men participation in maternal and child health care in Sub-Saharan Africa and revealed that male participation in ANC was influenced by marital status.

The results of this study support the findings obtained by Ditekemena et al., who conducted a review on barriers to male participation in maternal health services in sub-Saharan Africa and revealed that marital status had influence on men participation in ANC. Similarly, findings of this study confirmed by the results reported by Doe, that showed a significant association between age of men, marital status and his level of participation in ANC (Doe R, 2013). Similar findings were also found by Craymah et al, whose study revealed that men participation in ANC influenced by marital status, number of children and living with partners. On the other hand, the findings of this study are contrary to that reported by (Nantamu D,2011). Nantamu reported association of employment status with increased likelihood of the male involvement in ANC, and age of men has no influence on men decision on escorting his wife

(Nantam D, 2011). The possible factors for these findings could be due to the fact that the views of men on whether they participate in antenatal care or not depends on their socio-demographic characteristic, that vary among the respondents.

5.3.2 Socio-Cultural Barrier to Men Participation in ANC

On the socio-cultural barrier to men participation in ANC, the study's finding that men will be perceived as they are ruled by their spouses if they are seen accompanying their partners to the clinic concur with the findings reported by Ditekemenna et al, who discovered that poor perception of male partners associate with low men participation in ANC.

These findings also supported by the results of the study conducted by (Vyonne et al,2020) where men responded that if they are seen accompanying their partners to clinic community members will mock them and be understood as they are controlled with women.

Again, the findings that It is not acceptable for men to carry women's home chores during pregnancy is similar to findings of Doe done in Ablekuma, Accra, Ghana on male participation in maternal health care and found that there were no traditions and customs which prohibit men participation in ANC although there is strong concern about how the community members and relative perceived when they see a man accompanying women to the ANC clinic (Doe R,2013). Craymah et al who conducted a study about men involvement in maternal and child health also found that prohibitive gender roles and cultural norms are barrier to men participation in ANC (Cryamah et

al, 2017). The presence of cultural and gender norms in some Tanzanian societies, which believe that males should not be ruled by their women, could explain these findings. Where these culture and gender norm exist, male participation in ANC is negatively affected.

5.3.3 Socio-Economic Barriers to Men Participation in ANC

On social economic barrier lack of health insurance cover was associated with low men participation in ANC this may be due to some medical care need to be covered by paying some amount for RCH services. Women with health insurance are more likely to have proper timing of the first antenatal attendance and get skilled birth assistance at delivery (Kibusi et al, 2018). The government of Tanzania, subsidizes maternal and child health care services where by user-fee exemption is given in public health centers (Shija A,2011). However, pregnant women, on the other hand, face some hidden costs when seeking medical help (Shija A, 2011). Such costs may arise due to long distance of travelling to seek medical care, lack of essential medicines and equipments in public health facilities necessitating them to buy in private drug shops, non-official payments to the health care providers, and time spent due to big number of patients in facilities with inadequate health care workers (Kibusi et al, 2018). In Tanzania, high out-of-pocket (OOP) expenses create barriers to access reprouctive and child health care (Kibusi et al, 2018). Health insurance is a good way to cut down on out-of-pocket expenses. It lowers catastrophic payment and improves health-seeking behavior and utilization of health services. It is also linked to ANC attendances and may enhance the number of health facility deliveries attended by skilled health (Shija A,2011, Dixon J,2014).

In addition to social economic barriers, the study revealed that the family which own car or motorbike were more likely to participate in antenatal. This may be due to the factor that the man who own motorbike or car can escort his wife and save time for other economic activities (Dixon J,2014). The concern about saving time when it comes to escort pregnant women was also reported Kenya which indicated that motorbike drivers "bodaboda' where more likely to accompany their partners compared those who didn't own transportation (Sally J,2017).

5.3.4 Health Facilities Barrier To Men Participation in ANC

On health facilities barriers the findings of the current study reveal that long waiting time at the health facilities, and distance to health facility are barriers to men participation in antenatal care.

The findings of Nantam et al, who discovered that extended long waiting time at the health facility is associated with poor men participation in ANC, agree with the findings of this study (Nantamu D et al, 2011) Similarly, the findings concur with the result reported by Secka et al. who revealed that extended long waiting time for laboratory and ANC service are health facilities contributing factors for poor men participation in ANC. However the findings of this study on long waiting time is contrary to the finding of Doe who reported that the long waiting time is subjective and cannot be measured and confirmed as real barriers to men participation in ANC (Doe R, 2013).In the current study the reason for distance and longtime waiting for services at the health facility being barriers to men participation in ANC could be due

to the fact that in Tanzanian healthcare services is delivered through a number of processes that take a long time.

As such, pregnant women who come for ANC visit spend more time at the ANC clinic before being treated. Men who accompany their spouses to ANC appointments and are dissatisfied with the environment at the health facilities may be discouraged from attending with their wives to the follow up ANC visit (Maluka et al, 2018).

Finally, the nature of services at health facilities may play a role in making men feel that their attendance at the facility is important or not, they may feel their presence is important in ensuring good services provided to their wives.

5.3.5 Qualitative Assessment

The finding of this study shows that male partners want to be more active involved in ANC as well as the women need to be accompanied by their partners. Respondents perceived men as being the one support the family financially and are breadwinners. There is consensus among participants that male partners are expected not only to support their wives financially, but also be in charge to prepare essential items required during pregnancy and deliveries and support women during ANC. Similarly, some women were comfortable to go for ANC visit alone, but they are happy if men accompany them for the first ANC visit in order to test HIV. The findings of this study concur with other study in Ghana which reported that removing the financial barrier to ANC services is thought to help increase utilization of health care services (Dickson J,2014). Following advantages of ANC services, postpartum care and hospital

delivery, active male involvement is important. ANC visits give an opportunity for couple to receives health education about risk in pregnancy and delivery (Sigh P,2012). The couples also receive couple counselling and HIV testing (Sigh P,2012).

The study's findings also revealed that men's fears of HIV test prevent them from accompanying their wives to health facility for ANC.The findings of the study further reported that fear of HIV testing deter men to accompany their spouses to health facilities for ANC. Previous studies revealed that most of male partners are afraid of HIV testing because HIV is associated with disclosure and stigma (Maluka S, 2014). While many studies reported that with the presence antiretroviral therapies, people showed acceptance of their HIV status, and currently HIV is becoming accepted in societies as other diseases (Maluka S,2014), in some communities perceived stigma is associated with their decision in disclosing or the HIV status (Byamugisha et al,2010). It’s also likely that male partners are afraid of being tested positive in the presence of their wives due to its implication on their relationships. There is requirements of increasing education and community sensitization on the advantages of routine couple counselling and HIV testing (Byamugisha et al, 2010). The study that was conducted by Kululanga and colleagues revealed how the utilization of men peer’s initiatives, incentives, and sensitization encourages men to actively involved in ANC in Malawi. Therefore, more effort done by stakeholders and government in addressing the stigma linked to the disclosure of HIV should be increased.

The current study reported that health facilities have unsupportive environments for men participation in ANC. For instance, infrastructures discourage men involvement

in reproductive health care including specific services for men such as voluntary male circumcision. There are evidences that following nature of ANC services infrastructures, male partners are prohibited to enter in the ANC service rooms. The health care systems attempt to maintain the privacies of other women during health care services and delivery. Lack of infrastructures for accommodating men has been reported to prohibit male involvement in reproductive health including ANC and child birth (Diketemena et al,2011) These findings signify that interventions to promote men participation in maternal and reproductive health care requires major transformations of the health systems including policy development, program plans and implementation (Mtae H, 2015).

CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.1 Chapter Overview

This study examined the determinants of male involvement in antenatal care in selected social demographic characteristics, social-cultural, social-economic and health facilities factors, and below are conclusion and recommendations. This chapter ends with the suggestion for further studies.

6.2 Conclusion

6.2.1 Objective 1: To Determine the Social-Cultural Factors Influencing Male Participation in ANC

Social cultural factors were found to have significant influences on male involvement in antenatal care. This is because men are traditionally favored by gender roles and cultural norms. Some men feel shy to carry the chores of their wives while going to the clinic and some men are mocked if they are seen walking together with his wife to ANC clinic. It seems like they are ruled or controlled by their partners. Dominance of male as the main breadwinner of the family has negatively affected the male participation in ANC, men utilize more time for financial family support.

6.2.2 Objective 2: To Determine the Economic Factors Influencing Male Participation in ANC

Economic factor was reported as the barrier toward influencing male to participate in ANC. Lack of health insurance cover was the main issue raised, the couple pay a lot

of contributions when they visit the clinic, few services are waived however health care supplies such as drugs and diagnostic tests are still few in government clinics, hence increases the costs of services. In addition, the family with no transportation as to incur more cost to travel to the health facilities, in order to reduce these costs, the women s going alone.

6.2.3 Objective 3: To Assess the Health-Facilities Factors Influencing Men Participation in ANC

Men reported feeling unwelcomed and disrespected at the heath facilities. The space is too congested and there is little chance of confidentiality hence they fear to go there and be tested HIV. There is long waiting time and more time is spent waiting for laboratory and ANC services. In addition, language from some health workers are discouraging male participation, sometimes men are asked if they are pregnant by HCWs.

6.3 Recommendation

District health managers and other reproductive health stakeholders should increase efforts to improve gender relations, strengthen men's knowledge of their social roles in reproductive, maternity, and child health issues, and provision of male-friendly services.

Some ways which are possible for male involvement could be through engaging male champions. Champion men could be recognized in the society, capacitated, and encouraged to mentor other male partners on active participation in antenatal care.

Community, religious and tradition leaders should be used to champion promotion of men participation in reproductive health issues including antenatal care. Interventions that promote gender equality and recognize men as change agents, improve couples' communication, and increase male partners' engagement in birth preparation should be encouraged.

Health facilities should be renovated and new facilities should be built in ways that can accommodate male partners and promote their involvement in ANC. In addition, the government should ensure presence of adequate of health care workers in in order to reduce the long waiting time.

6.4 Areas for Further Studies

This study is just a cross sectional study at lower levels. Many determinants which were discussed in this study require further researches with varying analysis in order to get better and more understanding of determinants of male involvement in ANC as well as reproductive, maternal and child health in Tanzania. Whether these discussed factors affect male participation in ANC as it was stated by respondents of this study that cannot be conclusive, the comprehensive study should be done which include policy makers at ministry level, health managers, health providers and community leaders.

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APPENDICES

Appendix I: Questionnaire for Men

The purpose of the study is to find out the barriers to male involvement in antenatal care in Nyamagana Municipal. I will be very glad if you can provide responses to the set of questions to the best of your knowledge and understanding. You are free to withdraw from the study at any given point in the process of data collection. However, your responses will be treated with confidentiality and will be used solely for academic purpose. This exercise will last for about 20 minutes. The results of the study will help improve upon the level of male involvement in antenatal care in Nyamagana district. My contact number is 0711286971. **Thank you for your time and cooperation.**

SECTION A: Socio-Demographic Characteristics of Respondents

1. Age
   - A. 18- 29 years [ ]
   - B. 30-39 years [ ]
   - C. 40-49 Years [ ]
   - D. 50 and above [ ]

2. Marital status
   - A. Married [ ]
   - B. Cohabiting [ ]
   - C. Separated/Divorced [ ]

3. Educational level completed
   - A. No formal education [ ]
   - B. Primary [ ]
   - C. Secondary [ ]
   - D. Diploma [ ]
   - E. University level [ ]
   - F. No formal education [ ]

4. Occupations
   A. Unemployed [ ]
   B. Self-employed [ ]
   C. Civil/Public servant [ ]
   D. Private sectors [ ]

5. Number of children
   A. 1 Child [ ]
   B. 2 - 4 Children [ ]
   C. 5 or more Children [ ]

Age of last child…….

6. Are you living together with your partner?
   A. Yes [ ]
   B. No [ ]

SECTION B: Level of Male Involvement in Antenatal Care

Variables	**Yes**	**No**
Did you involve in the decision on where your wife had antenatal care?		
Have you ever accompanied your partner to the antenatal clinic in the last pregnant?		
Do you discuss with your partner the outcome of ANC visits with her?		
Do you provide funds to your partner for her ANC visits?		
Do you inform or remind your partner to go for ANC visits?		
Do you discuss with your health care providers about health issues related to your partner pregnancy?		
Do you talk to your partner always about her pregnancy, especially to know how she feel?		

SECTION C: SOCIO-CULTURAL DETERMINANTS

Do you agree to the following factors as influencing your involvement in ANC.? Please indicate whether YES (**Y**) or NO (**N**) to the set of questions below

Variables	**Y**	**N**
. It is not acceptable for men to carry women's home chores during pregnancy		
. Men will be perceived as they are ruled by their spouses if they are seen accompanying their partners to the clinic.		

. Culturally, husbands are not allowed to accompany their partners to ANC clinic		
. Being mocked by friends prohibit men to escort their spouses to the clinic		
. A women can perform her routine duties regardless of her pregnancy		

SECTION D: Socio-Economic Determinants

Do you agree to the following factors as influencing your involvement in ANC.? Please indicate whether YES (**Y**) or NO (**N**) to the set of questions below

Variables	**Y**	**N**
. Do you or your partner have insurance cover to cater for your health		
. Is your monthly income equal or above 100,000 Tsh		
. Does your partner monthly income equal or above 100,000 Tsh		
. Does your household monthly income above or equal to 150,000 Tsh		
. Do you have family motorbike or a car		
. Have you/ your partner ever missed ANC clinic due to lack of transport or health service fee		

SECTION E: Health Facility Determinants

Do you agree to the following factors as influencing your involvement in ANC.? Please indicate whether YES (Y) or NO (N) to the set of questions below

Variables	**Y**	**N**
. I have insufficient time to escort my partner to ANC in regular visits		
. No enough space in ANC clinic for men to be accommodated together with their partners		
. Healthcare costs prohibit me to escort my spouse to the ANC		
. Health facilities are located to long distance area and that prohibit me to accompany my partners to ANC		
. Being mocked by health care providers prohibits male partners from accompanying their spouses for ANC		
. Men are hesitant to escort their spouses to the facility for ANC since they are not involved in many things happening at the clinic or assessments of their partners		
. Male partners are unable to escort their spouses for ANC due to long waiting time spend at the health center		

THANK YOU FOR YOUR TIME AND COLLABORATION

Appendix II I : Focused Group Discussion guide questions

1. Have you ever escorted by your spouse to attend the antenatal care during this or previous pregnancy?
   Yes No
2. If NO, state the reasons for not being escorted to attend antenatal care.

……

……

3. What do you think are the benefits of attending antenatal care as a couple?

……

……

4. What would you say about the attitude of the health care providers working in the antenatal care towards the clients or male participation in ANC?

……

……

5. 5. What do you think are some of the factors in the antenatal care clinic that would make men not accompany their partners during antenatal care visit?

……

……

6. State any other health facility associated reasons that could be preventing men from attending the antenatal care?

……

……

7. What strategies can we use to encourage other men to accompany their spouses to the antenatal clinic?

……

……

THANK YOU FOR YOUR TIME AND COOPERATION

Appendix IIII: Clearance Letter

THE OPEN UNIVERSITY OF TANZANIA

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Our Ref: PG201986188 **4th June 2021**

District Executive Director (DED),

Nyamagana Municipal Council,

P.O.Box.1333

MWANZA.

RE: RESEARCH CLEARANCE

The Open University of Tanzania was established by an Act of Parliament No. 17 of 1992, which became operational on the 1st March 1993 by public notice No.55 in the official Gazette. The Act was however replaced by the Open University of Tanzania Charter of 2005, which became operational on 1st January 2007.In line with the Charter, the Open University of Tanzania mission is to generate and apply knowledge through research.

To facilitate and to simplify research process therefore, the act empowers the Vice Chancellor of the Open University of Tanzania to issue research clearance, on behalf of the Government of Tanzania and Tanzania Commission for Science and Technology, to both its staff and students who are doing research in Tanzania. With this brief background, the purpose of this letter is to introduce to you **Mr. KINYINA, Alen Reg No: PG201986188** pursuing **Master of Arts in Monitoring and Evaluation (MAME).**We here by grant this clearance to conduct a research titled **" Barriers to Male Participation in Antenatal Care in Nyamagana District, Tanzania".** He will collect His data at your Area from 7th June 2021 to 30th June 2021.

In case you need any further information, kindly do not hesitate to contact the Deputy Vice Chancellor (Academic) of the Open University of Tanzania, P.O.Box 23409, Dar es Salaam.Tel: 022-2-2668820.We lastly thank you in advance for your assumed cooperation and facilitation of this research academic activity.

Yours,
THE OPEN UNIVERSITY OF TANZANIA

Prof. Magreth Bushesha
DIRECTOR OF POSTGRADUATE STUDIES.