

Gendered Dimensions of Health-Seeking Behaviour: Evidence from Caregivers of Children Under Five in Morogoro Municipality, Tanzania

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ABSTRACT

Gender norms play a critical role in influencing health-seeking behaviour, yet their influence on caregivers' decision-making for children under five remains underexplored in Tanzania. This study examined how culturally constructed gender roles affect caregivers' ability to recognise illness, make healthcare decisions, and access timely treatment in Morogoro Municipality. A qualitative research design was employed, combining semi-structured interviews, focus group discussions, and non-participant observations with 12 caregivers. Thematic analysis revealed three main findings: (i) women are the primary caregivers responsible for identifying and monitoring childhood illnesses but face limited autonomy due to male authority and financial control, (ii) men's roles as household heads and financial providers grant them ultimate decision-making power over healthcare access, and (iii) women exercise situational agency, particularly during emergencies, though these actions often risk social disapproval. The findings are interpreted through the lens of the Gender and Development (GAD) theory, highlighting how gendered power relations mediate health-seeking behaviours and influence child health outcomes. The study underscores the need for interventions that address structural gender inequalities, including community education, male engagement in child health responsibilities, and women's economic empowerment. By enlightening the intersection of gender norms and child health, this research contributes to advancing SDGs 3 (good health and well-being) and 5 (gender equality) in low-resource contexts.

Keywords: Gender norms, health-seeking behaviour, caregivers, children under five, Tanzania.

INTRODUCTION

Globally, prompt and appropriate care-seeking for common childhood illnesses remains a cornerstone of efforts to reduce under-five morbidity and mortality. Infectious diseases such as pneumonia, diarrhoea, and malaria, together with neonatal causes and malnutrition, continue to be leading contributors to child deaths in low- and middle-income countries (World Health Organisation [WHO], 2024). Improving caregivers' recognition of illness and promoting timely utilisation of health services are therefore essential strategies for enhancing child survival outcomes (Colvin *et al.*, 2013).

Health-seeking behaviour for childhood illnesses is shaped by a complex interplay of factors, including caregivers' knowledge and perceptions of illness severity, availability and quality of health services, household socio-economic status, and broader social and cultural norms (Kanté *et al.*, 2015). Evidence from diverse Tanzanian settings highlights that caregivers' decisions about whether, when, and where to seek care are influenced both by individual-level beliefs and by structural constraints such as cost, distance, and service readiness (Mburu *et al.*, 2021). These determinants interact dynamically—for instance, perceived illness severity may prompt care-seeking only when transport and finances are available, while social networks or community health workers may mediate access to formal care (Feldhaus *et al.*, 2015).

A growing body of research emphasises the central role of gender norms in shaping health-related behaviours and access to care. Gender norms—socially shared expectations about appropriate roles, responsibilities, and

behaviours for men and women—influence who makes health decisions, who controls household resources, and what forms of care are considered acceptable (Barasa *et al.*, 2022). In maternal, newborn, and child health contexts, men's involvement (or lack thereof), women's autonomy, and gendered expectations about caregiving responsibilities have all been shown to affect timely utilisation of services (Greenspan *et al.*, 2019). Studies from Tanzania in particular highlight gendered decision-making patterns and male gatekeeping as important drivers of delays or variations in care-seeking (Lyimo *et al.*, 2024).

Despite this conceptual recognition, there remain important empirical gaps regarding how specific gender norms operate within local contexts to shape caregivers' health-seeking behaviour for children under five. Studies in Morogoro and adjacent regions have explored aspects of male involvement, community health worker gender dynamics, and local health literacy, but few directly link local gender norms to measurable care-seeking practices for under-five children (Feldhaus *et al.*, 2015; Mburu *et al.*, 2021). This gap is significant, as interventions that overlook local gender relations risk failing to reach children in need or may inadvertently reinforce inequitable care patterns (Barasa *et al.*, 2022).

This paper examines the gendered dimensions of health-seeking behaviour among caregivers of children under five in Morogoro Municipality, Tanzania. Specifically, it analyses caregivers' reported care-seeking actions alongside qualitative insights about household decision-making and normative expectations. The study aims to (a) identify which gender norms most strongly influence decisions about seeking care for sick children, (b) document how these norms interact with other barriers such as economic or service-related constraints, and (c) suggest implications for gender-sensitive programming to improve timely and appropriate care for young children. Addressing these aims contributes to both the local evidence base for Morogoro and the broader literature on gender and child health in sub-Saharan Africa (Colvin *et al.*, 2013; Greenspan *et al.*, 2019; Barasa *et al.*, 2022).

The rest of the paper is organised as follows. Section 2 presents the theoretical perspective guiding the study. Section 3 describes the research methodology employed. Section 4 presents the study findings, highlighting the role of gender norms in influencing caregivers' health-seeking behaviour. Section 5 discusses these results and outlines their policy and practical implications. Section 6 addresses the study's limitations and proposes directions for future research. Finally, Section 7 concludes the paper by summarising the key findings and drawing implications for policy, practice, and further gender-sensitive interventions.

Theoretical Perspective

This study was guided by the Gender and Development (GAD) theory, which provides a comprehensive framework for understanding how socially constructed gender relations influence individual behaviour and access to social services, including healthcare. The GAD perspective emerged in the 1980s as a response to the limitations of the earlier Women in Development (WID) approach, which focused narrowly on women's inclusion in development projects without addressing the underlying structural inequalities between men and women (Rathgeber, 1990). Unlike WID, the GAD approach emphasises the social construction of gender roles, power relations, and institutional dynamics that determine how men and women participate in, contribute to, and benefit from development processes (Moser, 1993).

The core assumption of the GAD framework is that gender is not biologically determined but is a socially and culturally constructed system of roles and expectations that assigns men and women different responsibilities, rights, and levels of power in society (March *et al.*, 1999). These socially defined roles influence how resources, decision-making power, and opportunities are distributed within households and communities. In the context of health, gender norms shape who controls financial resources, who makes decisions about seeking care, and whose health is prioritised. Consequently, health-seeking behaviour cannot be understood solely at the individual level but must be analysed within the broader context of gendered social relations (Moser, 1993; Parpart, 1993).

In this study, the GAD theory provided the conceptual lens for examining how gender norms and power relations within households affect caregivers' decisions to seek healthcare for children under five in Morogoro Municipality. Specifically, the theory guided the analysis of how men's authority in household decision-making and women's caregiving roles influence the timeliness and choice of healthcare services. For example, women's limited autonomy in financial decisions or the need to obtain permission from husbands before seeking care can

delay treatment for sick children, while male perceptions of caregiving as a female responsibility may reduce paternal involvement in child health (Greenspan *et al.*, 2019). Moreover, the GAD perspective drew attention to the institutional and structural factors that reinforce gender inequalities in healthcare access, including cultural norms, health system practices, and socioeconomic barriers. This theoretical orientation helped interpret how gender norms are reproduced through both household-level interactions and broader community structures. The framework, therefore, informed the formulation of research questions, the design of data collection tools, and the interpretation of findings by highlighting how gendered power dynamics and social expectations shape caregivers' health-seeking practices in the study area.

By applying the GAD theory, the study moved beyond descriptive accounts of individual behaviour to explore the underlying social relations that perpetuate inequities in child health outcomes. This theoretical orientation underscores the importance of designing gender-sensitive interventions that not only target caregivers but also engage men, community leaders, and institutions in transforming harmful gender norms that limit timely and appropriate health-seeking for children under five.

MATERIALS AND METHODS

Study Area

The study was conducted in Morogoro Municipality, Tanzania, a region characterised by diverse socio-economic and spatial settings, encompassing urban, peri-urban, and rural communities (URT, 2022). This diversity provided an ideal context for exploring cultural variations in health-seeking behaviour. The municipality hosts both formal and informal healthcare systems, ranging from hospitals and clinics to traditional healers (MoH, 2022; NBS, 2022), and faces persistent public health challenges such as typhoid, partly due to inadequate water, sanitation, and hygiene (WHO, 2011; Msambali & Mwonge, 2025).

Research Approach

This study employed a qualitative research approach to gain an in-depth understanding of caregivers' knowledge, perceptions, and cultural influences influencing health-seeking behaviours for children under five. Qualitative inquiry allows flexibility in probing participants' responses, thereby uncovering nuanced realities and hidden meanings (Lim, 2025; Flick, 2018). Through this approach, the researcher was able to explore how gender norms influence decision-making processes related to child health.

Research Design

A cross-sectional research design was adopted to examine cultural influences on caregivers' health-seeking behaviours at a specific point in time. This design facilitated the identification of patterns and associations among key variables, including traditions, norms, and beliefs (Bryman, 2016). It also enabled data collection from a representative sample of caregivers, thereby providing a snapshot of the prevailing cultural and behavioural contexts affecting child health outcomes (Kothari, 2009; Creswell, 2014).

Population and Sampling Procedures

The target population comprised caregivers of children under five, including parents, guardians, and other household members responsible for childcare. A multistage sampling technique combining purposive and snowball approaches was employed (Sedgwick, 2015). Initially, purposive sampling identified information-rich participants based on their caregiving experience and familiarity with cultural health beliefs. Subsequently, snowball sampling was used to expand participation through referrals (Naderifar *et al.*, 2017), ensuring trust, accessibility, and diversity in viewpoints. Data collection continued until theoretical saturation was achieved after 12 interviews (Rahimi & Khatooni, 2024).

Data Collection Methods

To ensure methodological triangulation and enhance validity, data were collected through interviews, focus group discussions (FGDs), and non-participant observation (Denzin & Lincoln, 2011; Patton, 2015). Semi-structured interviews were conducted with caregivers and key informants, including health workers, traditional

healers, religious leaders, and community elders. FGDs comprising four caregivers each were used to explore collective beliefs and practices, while observations captured contextual behaviours and social interactions influencing health decisions.

Data Analysis

Thematic analysis guided data interpretation (Braun & Clarke, 2006). Transcripts were coded and categorized to identify recurring themes related to gender norms influencing health-seeking behaviour among caregivers of children under five. Findings were presented thematically with illustrative quotes, highlighting similarities and differences across participant groups. The results were discussed in relation to the GAD theory and relevant literature, ensuring that the interpretations were both conceptually grounded and contextually meaningful.

RESULTS

This study examined how gender norms shape caregivers' health-seeking behaviour for children under five in Morogoro Municipality. The findings reveal that cultural expectations and socially constructed gender roles strongly influence who provides care, who makes health-related decisions, and how resources are controlled and allocated within households (Bedford & Sharkey, 2014; Wambui *et al.*, 2018). In line with earlier studies in African contexts (Bakare *et al.*, 2020; Muraya *et al.*, 2021), women were found to occupy the central caregiving role but with limited decision-making power, while men were positioned as financial providers and ultimate decision-makers. These gendered divisions of roles often determined whether and when children received medical attention.

The results are presented under three major themes: (1) Women as primary caregivers with limited autonomy, (2) Male authority and control over healthcare decisions, and (3) Negotiation, resistance, and consequences for child health.

Women as Primary Caregivers with Limited Autonomy

Caregivers consistently reported that women are culturally expected to be the first to identify signs of illness and initiate responses. Mothers were described as the ones who stay with children, monitor their conditions, and comfort them during sickness. However, despite their central caregiving role, many women expressed limited autonomy in deciding when and where to seek formal healthcare.

For instance, one caregiver explained:

... when the child is sick, I first inform my husband. He decides if we go to the hospital or try medicine at home, because he controls the money. I may know the child needs a doctor, but without his support, I cannot go. (CG01, Female, 24 years)

This testimony illustrates the structural imbalance of power within households. Although women have practical knowledge of a child's condition, their dependence on men for financial resources and approval limits their agency. This finding reflects earlier studies that describe men, as household heads and financial providers, as dominant actors in healthcare decision-making in patriarchal societies (Bakare *et al.*, 2020; Wambui *et al.*, 2018). Such dynamics can create critical delays in accessing formal medical care, particularly when illnesses require urgent attention.

Male Authority and Control over Healthcare Decisions

Men were widely described as the household heads and financial providers, roles that granted them authority over healthcare decisions. Caregivers explained that cultural expectations required men to approve hospital visits, particularly when costs were involved.

A male respondent illustrated this dynamic:

... the mother must stay with the child, comfort and monitor him, but the father's role is to provide money for treatment. It is not expected for a man to sit with a sick child the whole day. (CG05, Male, 40 years)

This reflects the entrenched division of labour where caregiving is feminised, while financial provision and decision-making authority remain masculinised. Such norms reinforce male gatekeeping over access to formal care, which often results in treatment delays. As Wambui *et al.* (2018) argue, women's restricted autonomy in patriarchal households is a major barrier to timely health-seeking, with direct implications for child health outcomes.

Negotiation, Resistance, and Consequences for Child Health

Although dominant gender norms restricted women's autonomy, some caregivers reported instances of negotiation and quiet resistance, especially during emergencies. Urgency sometimes compelled women to bypass social expectations to protect their children.

One caregiver attested that:

... if it is urgent, like when the child has convulsions, I don't wait. I take the child to the hospital even without telling my husband first. Later I explain, because I cannot risk the child's life waiting for him to decide. (CG09, Female, 36 years)

This response shows that women sometimes negotiate or resist cultural norms when faced with emergencies. While structural constraints persist, urgency and perceived risk can empower them to act independently. Similar observations have been made in Kenya, where mothers occasionally bypass patriarchal authority to protect their children's lives (Muraya *et al.*, 2021; Bedford & Sharkey, 2014). Yet, these actions often remain exceptions rather than the norm.

Nevertheless, such actions were not without consequence. Some caregivers reported social disapproval when they bypassed elders or husbands. One caregiver admitted:

... sometimes I cannot go to the hospital immediately, because I must wait for my husband to agree. If I go without his permission, it can bring conflict. (CG04, Female, 36 years)

This highlights how gendered power relations within households can delay timely healthcare, a finding echoed by Wambui *et al.* (2018), who noted that women's restricted autonomy contributes to poor child health outcomes in patriarchal settings.

Another caregiver added:

... children suffer when fathers do not provide money quickly, or when mothers are blamed for rushing to the hospital without asking. These delays can make the sickness worse, and sometimes the child ends up more seriously ill. (CG03, Female, 57 years)

This underscores the broader implication that gender norms not only determine the distribution of responsibilities but also significantly shape child health outcomes. When rigid cultural expectations limit women's decision-making autonomy, children face increased vulnerability to preventable illness and delayed care. Conversely, when gender relations are more flexible, caregivers can act promptly, leading to better outcomes.

DISCUSSION AND POLICY IMPLICATIONS

Discussion of the Results

The findings of this study demonstrate that gender norms play a central role in shaping caregivers' health-seeking behaviour for children under five in Morogoro Municipality. Although women are culturally positioned as the primary caregivers, their autonomy in making health-related decisions is often constrained by entrenched gendered power relations within households. These constraints manifest through cultural expectations that prioritise male authority in decision-making, particularly regarding the use of financial resources. As observed in this study, women frequently required approval or financial support from their husbands before seeking biomedical care for their children—a situation that often led to treatment delays. Similar findings have been

reported in other African contexts, where patriarchal norms reinforce male control over healthcare decisions, thereby increasing children's vulnerability to preventable diseases (Bakare *et al.*, 2020; Wambui *et al.*, 2018; Ngere *et al.*, 2025a,b).

These results are consistent with a broader body of literature from developing countries. For example, Bakare *et al.* (2020) found that in Nigeria, men's financial control and dominance within households constrained women's capacity to access timely healthcare for their children. Likewise, Muraya *et al.* (2021) observed in Kenya that women, despite being the first to recognise illness symptoms, often relied on men's final approval for hospital visits. Such cross-contextual evidence underscores that gender norms function as structural barriers to equitable and timely healthcare access across many low- and middle-income settings.

The findings of this study can be interpreted through the lens of the Gender and Development (GAD) theory, which emphasises the socially constructed nature of gender relations and their influence on access to resources, decision-making, and opportunities (Rathgeber, 1990). Within this theoretical framework, caregivers' health-seeking behaviour in Morogoro Municipality is not simply a matter of personal choice or knowledge but is embedded within social systems that privilege male authority. For instance, the expectation that mothers must seek approval from husbands or elders before taking a child to a health facility reflects deeply rooted gender ideologies that shape behaviour and constrain women's agency. This interpretation aligns with Asefa *et al.* (2020), who found that in Ethiopia, mothers' knowledge of illness was insufficient to prompt healthcare utilisation when cultural norms limited their decision-making autonomy.

Interestingly, this study also found evidence of negotiation and resistance, particularly in emergency situations. Some mothers exercised agency by bypassing traditional hierarchies and taking their children directly to hospitals without prior consultation. These acts of defiance reflect the dynamic and context-dependent nature of gender norms—where urgency and perceived risk can temporarily override patriarchal constraints. Similar findings have been reported in Uganda (Rutebemberwa *et al.*, 2009) and Kenya (Muraya *et al.*, 2021), where mothers acted independently in life-threatening circumstances. Nonetheless, these actions often led to domestic conflict or social disapproval, highlighting the precariousness of women's autonomy in patriarchal contexts.

Overall, the findings illustrate that gender norms serve as both direct and indirect determinants of health-seeking behaviour. While women carry the primary responsibility for caregiving, their ability to convert knowledge of illness into timely health action is mediated by male authority, financial dependency, and cultural constructions of masculinity and femininity.

Policy Implications

From a policy perspective, improving child health outcomes requires interventions that move beyond individual-level education and address the underlying gender inequalities that structure decision-making. Gender-transformative health programmes should focus on promoting shared responsibility between men and women in child health care. Community health campaigns and public education initiatives can help challenge restrictive gender norms by highlighting the importance of joint decision-making in ensuring timely healthcare access.

Furthermore, women's economic empowerment—through microfinance schemes, savings groups, or income-generating activities—can reduce financial dependency and strengthen their bargaining power in household health decisions. Evidence from Bangladesh shows that programmes engaging men in maternal and child health responsibilities have successfully improved health-seeking practices and reduced delays in treatment (Story & Burgard, 2012). Similar gender-inclusive interventions could be adapted and scaled up in the Tanzanian context to promote equitable access to child healthcare services.

Limitations and Directions for Future Research

Despite offering valuable insights into the cultural influences shaping caregivers' health-seeking behaviour for children under five in Morogoro Municipality, this study is not without limitations. First, the use of a qualitative research design, while effective in capturing depth and contextual richness, limits the generalisability of the findings to wider populations beyond the study area. The results, therefore, should be interpreted as context-specific insights rather than representative of all caregivers in Tanzania or sub-Saharan Africa. Second, the

relatively small sample size and the reliance on self-reported data may have introduced potential biases such as recall inaccuracies or social desirability tendencies, where participants might have provided responses perceived as socially acceptable rather than their genuine experiences.

Given these limitations, future research should consider adopting mixed-methods approaches that combine qualitative depth with quantitative breadth to enhance the robustness and generalisability of findings. Expanding the geographical scope to include multiple regions within Tanzania—or across other sub-Saharan African contexts, would also allow for comparative analysis of cultural and contextual variations in health-seeking behaviours. Moreover, longitudinal research designs are also recommended to examine how gender norms influence caregivers' health-seeking behaviour over time. Such evidence could provide stronger empirical foundations for developing culturally sensitive health education programmes and policy interventions aimed at improving child health outcomes.

CONCLUSION

This study examined how gender norms shape caregivers' health-seeking behaviour for children under five in Morogoro Municipality. The findings revealed that while mothers are primarily responsible for identifying and managing childhood illnesses, their ability to act on these observations is often constrained by male authority and cultural expectations. In many households, fathers retained the power to approve decisions about seeking biomedical treatment, particularly when financial resources were required. Such gendered power relations frequently delayed access to healthcare, thereby compromising the timeliness and quality of child treatment.

Despite these constraints, instances of women's agency were evident, particularly during emergencies. Some mothers reported bypassing traditional hierarchies and taking their children directly to health facilities when illnesses were perceived as severe or life-threatening. These cases highlight that women's autonomy, although restricted, can be situationally activated by the urgency of a child's condition. Culturally, the division of roles that positions women as caregivers and men as financial providers perpetuates dependency and limits women's decision-making power. This structural imbalance reinforces patriarchal norms that prioritise men's economic authority over women's caregiving knowledge. Consequently, gender norms remain a critical determinant of health-seeking behaviour, influencing who makes healthcare decisions, how promptly care is sought, and what type of care is accessed.

In summary, the study underscores that improving child health outcomes in Morogoro Municipality requires more than raising awareness among caregivers—it demands a transformation of the underlying gender relations that govern household decision-making. Efforts to promote equitable health-seeking behaviour should therefore include gender-sensitive community education, male engagement in child health responsibilities, and economic empowerment programmes for women. Addressing these structural barriers is essential for fostering timely healthcare access and advancing both child well-being and gender equality. By highlighting the intersection of gender norms and health-seeking behaviour, this study contributes to the achievement of Sustainable Development Goal 3 (Good Health and Well-being) and Sustainable Development Goal 5 (Gender Equality), emphasising the importance of gender-responsive strategies in improving child health outcomes.

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