

Male Involvement in Antenatal Care - A Taboo or a Right? A Case of Zvishavane District

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ABSTRACT

Objective Male involvement in antenatal care (ANC) is an important strategy for improving maternal and neonatal health outcomes. Despite increasing policy support for men's participation in maternal healthcare, male attendance at ANC services remains low in many parts of sub-Saharan Africa, including Zimbabwe. This study explored factors influencing male participation in antenatal care in Zvishavane District, Zimbabwe.

Methods- An explanatory sequential mixed-methods design was employed. The quantitative phase involved a survey of 50 male partners of women who had recently delivered. Findings from the quantitative phase informed the development of interview guides used in the qualitative phase, which involved purposively selected healthcare workers providing maternal health services. Quantitative data were analysed using descriptive statistics, while qualitative data were analysed using thematic analysis. Integration of findings occurred during interpretation.

Findings- The quantitative findings showed that 52.0% (n = 26) of respondents had never attended ANC, 28.0% (n = 14) had attended once, and 20.0% (n = 10) had attended ANC two or more times. Major barriers identified included limited awareness of the importance of male participation, workplace commitments, financial constraints, cultural expectations, and health-system factors. Qualitative findings supported and expanded these results, revealing that prevailing gender norms often position pregnancy and ANC as women's responsibilities, while fear of HIV testing, inflexible clinic schedules, long waiting times, and unfriendly clinic environments further discourage attendance.

Conclusion- The integrated findings suggest that male participation in maternal healthcare is shaped by a complex interaction of individual beliefs, socio-cultural norms, economic realities, workplace demands, and health-system barriers. While physical attendance at ANC was generally low, some men reported supporting their partners through financial assistance. Interventions aimed at increasing male involvement should therefore address both structural and socio-cultural barriers while promoting broader forms of male engagement in maternal health.

Keywords: antenatal care, male involvement, maternal health,

INTRODUCTION

Male involvement in antenatal care (ANC) is increasingly recognized as a critical component in improving maternal and child health outcomes. Active participation of male partners has been associated with increased utilization of maternal health services, including skilled birth attendance and institutional deliveries (Muloongo et al., 2019; Suandi et al., 2019). Beyond physical attendance at health facilities, male involvement encompasses providing emotional, financial, and logistical support, as well as participating in decision-making regarding maternal and newborn health.

Globally, maternal mortality remains a major public health concern, with Sub-Saharan Africa contributing

approximately two-thirds of all maternal deaths (WHO, 2020). Despite numerous interventions aimed at improving maternal health outcomes in this region, male involvement in ANC remains low (Nkwonta & Messias, 2019). Evidence from countries such as Tanzania, Uganda, and Nigeria indicates that male participation enhances timely access to skilled care during pregnancy and improves overall maternal and neonatal outcomes (Galle et al., 2022; Gopal et al., 2020). However, male-focused strategies are still poorly integrated into maternal health programs.

Cultural and gender norms have been widely identified as significant barriers to male participation in ANC. In many societies, maternal health is traditionally perceived as a woman's responsibility, which discourages male engagement (Gibore et al., 2019). Additionally, lack of awareness, fear of HIV testing, stigma, and health system barriers further limit male involvement (Falade-Fatila & Adebayo, 2020; Moyo et al., 2024). A systematic review conducted in Ethiopia highlighted that entrenched cultural norms, rigid gender roles, and unfriendly healthcare environments continue to hinder male participation (Abebe et al., 2024).

Zimbabwe has made significant progress in reducing maternal mortality, with rates declining from 960 deaths per 100,000 live births in 2010 to approximately 212 per 100,000 live births in recent estimates (Musarandega et al., 2022; UNFPA, 2026). However, this remains far above the Sustainable Development Goal (SDG) target of less than 70 deaths per 100,000 live births by 2030 (UN, 2021). Neonatal mortality remains high at approximately 34 deaths per 1,000 live births (ZDHS, 2023/24), indicating persistent gaps in maternal and newborn healthcare.

In African countries, including Zimbabwe, men are often the primary decision-makers in households, particularly regarding access to healthcare (Shamu et al., 2025). This positions them as key influencers in maternal health outcomes. As a result, male involvement can be a key strategy for accelerating progress toward these targets. Countries, such as Rwanda and Malawi, have demonstrated progress through targeted interventions, including community engagement and male-friendly health policies, which have improved male participation and reproductive health outcomes (Chereni et al., 2022; Doyle et al., 2018).

At the local level, the situation in Zvishavane District highlights a significant concern. District data from September 2024 to February 2025 indicates that male participation in ANC is extremely low, with only 46 male partners attending out of 612 ANC visits—representing approximately 7.5%. This suggests that male involvement in ANC remains minimal despite its recognized importance, raising critical questions about whether such participation is viewed as a taboo or a right within the community.

Several factors influence male involvement in ANC, and these can be broadly categorized into socio-cultural, economic, and health system factors. Socio-cultural factors include patriarchal norms, beliefs about masculinity, and fear of social ridicule, which discourage men from attending ANC services. In some cases, men avoid participation due to fear of HIV testing or stigma associated with attending maternal health clinics (Nesane & Mulaudzi, 2024; Njokwe & Kijima, 2025).

Economic factors also play a significant role. Many men prioritize income-generating activities over attending ANC appointments due to financial responsibilities, transport costs, and opportunity costs related to time spent away from work (Ongolly & Bukachi, 2019; Mekonen et al., 2022). As a result, economic pressures often limit their availability and willingness to participate. Health system or institutional factors further contribute to low male involvement. Many healthcare facilities are not designed to accommodate male partners, with challenges such as long waiting times, inadequate infrastructure, and unfriendly staff attitudes discouraging men from attending ANC (Gibore et al., 2019; Sakala et al., 2021; Sao et al., 2024). These barriers highlight the need for more inclusive and male-friendly healthcare services.

Given these challenges, this study seeks to examine male involvement in antenatal care in Zvishavane District, focusing on whether it is perceived as a taboo or a right. It will specifically explore the socio-cultural, economic, and institutional factors influencing male participation, with the aim of generating evidence to inform interventions that promote greater male engagement in maternal healthcare.

METHODS

The study was conducted at Zvishavane District Hospital located in Midlands Province, Zimbabwe. The district hospital caters for both urban, mining and rural communities with diverse socio-economic conditions and cultural backgrounds, making it suitable for examining male behaviour and their involvement in maternal health services.

Research Design

This study adopted an explanatory sequential mixed-methods design. In the first phase, quantitative data were collected and analysed to determine the extent of male involvement in antenatal care and identify key barriers associated with attendance. Findings from the quantitative phase informed the second qualitative phase by identifying areas that required deeper exploration, particularly the low attendance rates, perceptions regarding men's roles in antenatal care. The qualitative phase was therefore designed to explain and contextualise the quantitative findings. Interview guides for healthcare workers were developed using results from the quantitative survey, enabling the researchers to explore reasons underlying observed patterns. Integration occurred at both the design and interpretation stages. Quantitative findings informed qualitative data collection, while qualitative findings were used to explain, expand, and contextualise the survey results. The final interpretation combined evidence from both datasets to provide a comprehensive understanding of factors influencing male participation in antenatal care.

Sampling

The study population included male partners of women who had recently delivered and were attending postnatal or child health services, healthcare workers involved in maternal health services. Since men are often difficult to reach in community settings, a convenience sampling technique was used to recruit 50 male participants from the postnatal ward at Zvishavane District Hospital. The sample size was determined based on feasibility, accessibility of the men during the study period, and the exploratory nature of the study. Although the sample is not intended to be statistically representative of all men in Zvishavane District, it provided sufficient information to identify patterns of male involvement and associated barriers. During visiting hours, eligible men who were aged 18 years or older, partners of women who had recently delivered, resided within the Zvishavane District catchment area and were willing to provide informed consent were invited to participate. Men who were critically ill, unable to communicate effectively, or unwilling to participate were excluded. For the qualitative sample, purposive sampling of healthcare workers with direct involvement in ANC service delivery was done. This method allowed efficient and cost-effective data collection with access to a relevant and available population. Participants included midwives and ANC focal personnel with at least two years' experience in maternal health services. Recruitment continued until thematic saturation was achieved. Non participatory observation was done to identify any males attending ANC with their wives

Data Collection

The questionnaire was developed following a review of literature on male involvement in antenatal care and adapted to the local context. The instrument included sections on sociodemographic characteristics, ANC attendance, perceptions of male roles, socio-cultural influences, economic barriers, and health system factors. Content validity was assessed through review by maternal health and public health experts. Prior to data collection, the questionnaire was pre-tested among a small group of men outside the study area to assess clarity, relevance, and comprehensibility. Necessary modifications were made following pilot testing. Quantitative data were collected from 50 male partners using a structured self-administered questionnaire which allowed standardized data collection for statistical analysis. The Quantitative data was used to structure the interview guides for the key informant. The interviews were conducted in a private setting after obtaining informed consent. Secondary data obtained from ANC registers was used to analyse trends in male participation from 2020 to 2024.

Data Analysis

Quantitative data were analysed using SPSS Version 16. Descriptive statistics including frequencies, percentages, means, and cross-tabulations were generated. Qualitative data was transcribed and analysed using thematic analysis. Coding was conducted using Microsoft Excel to identify recurring themes and patterns. Data is not available publicly as it was collected manually.

Ethical Considerations

Permission to carry out the research was obtained from the District Medical Officer (Zvishavane) while ethical approval was obtained from Medical Research Council of Zimbabwe (MRCZ)

Participants provided informed consent, and participation was voluntary. Confidentiality was ensured by anonymizing data and secure data storage with restricting access. All ethical principles, including respect for people, beneficence, and non-maleficence, were upheld.

Acknowledgement

AI tools (ChatGPT/Copilot) were used to assist in structuring and editing the manuscript. All content was reviewed and verified by the researcher.

FINDINGS

Demographic Data

The age, employment, education, marital status, and duration of residence of the participants are presented in Table 1

Table 1: Demographic Distribution (N=50)

Variable	N	%
Age in years		
18-29	17	34
30-39	22	44
40-49	9	18
50-59	2	4
Marital Status		
Married/Cohabiting	47	94.0
Separated/Divorced	3	6.0
Highest Level of Education		
No formal education	6	12.0
Secondary education	30	60.0

Tertiary/University education	14	28.0
Employment		
Formal	25	50
Informal	13	26
Unemployed	7	14
Peasant Farmer	5	10
Duration of Residence in Catchment Area		
Less than 1 year	1	2.0
1–5 years	20	40.0
More than 5 years	29	58.0

Most, (44.0%, n =22) participants were aged 30 to 39 years followed by the 18-to-29-year age group (34.0%, n = 17). The 40–49-year age group accounted for 18.0% (n = 9), while 4.0% (n = 2) were aged 50–58 years. The mean age was 35.5 years. Many participants were either married or cohabiting (94.0%, n = 47) whilst (6.0%, n=3 were either divorced or separated. Most had completed secondary school (60.0%, n = 30), while 28.0% (n = 14) held a tertiary qualification. Half of the participants (50.0%, n = 25) were formally employed, predominantly in the mining sector. A quarter (26.0%, n = 13) were informally employed or self-employed. The remaining participants were unemployed (14.0%, n = 7) or worked as small-scale farmers (10.0%, n = 5). The high proportion of mine workers is particularly relevant to the findings, as mining employment involves shift-based rosters with limited scheduling flexibility. More than half (58.0%, n = 29) had lived in the catchment area for over five years, indicating an established community sample familiar with local health services.

Factors Influencing Male Partner Participation in ANC

It is important to distinguish between male attendance at ANC and broader male involvement in maternal health. Although attendance at ANC clinics was generally low, several participants reported providing financial support, assisting with household responsibilities, and accompanying partners to health facilities without entering the consultation area. These findings suggest that male participation may occur in forms not captured solely by clinic attendance indicators.

Five themes that emerged from the data are:

- Low levels of male ANC attendance
- Lack of awareness as a barrier to attendance
- Limited understanding of the male role and responsibility in ANC
- Perceived supportive activities for male partners
- Sociocultural and economic challenges

Low Levels of Male ANC Attendance

Participants were asked how many times they had physically attended ANC with their pregnant partners during the most recent pregnancy. Results are presented in Figure 1

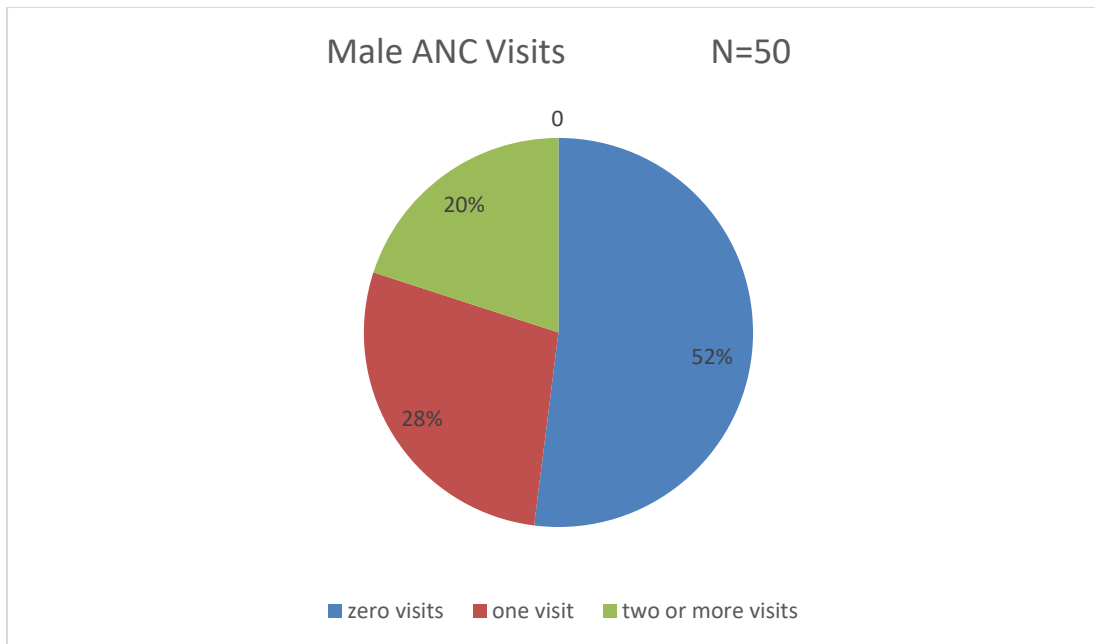


Figure 1 Number of Male ANC Visits

Figure 1 shows that more than half of the men (52.0%, n = 26) had never attended ANC with their partners at all. A further 28.0% (n = 14) attended only once, while just 20.0% (n = 10) attended two or more times. This means that 8 out of every 10 men attended ANC on zero or one occasion during the entire pregnancy.

Healthcare workers who participated in the key informant interviews confirmed this pattern:

ANC Focal Person - "From my experience here at this facility, male attendance at ANC is very low. In a typical week, out of all the women who come for antenatal care, very few are accompanied by their male partners. Most women come alone or with a female relative."

Nurse, ANC Unit - "I have been working in this ANC clinic for four years now. Men drop their partners here and leave. Some prefer to wait outside. They do not see the need to come in."

The researcher visited the ANC department twice a week for four weeks but not a single male was observed accompanying his wife but to drop and pick them

Data from the ANC registers show that very few men visit the ANC with their wives. Table 2 show ANC attendance and partner involvement at Zvishavane District Hospital, from September 2025 to February 2026

Table 2 Male Attendance at Zvishavane District Hospital from September 2025 to February 2026

Period	ANC visits	Number of Male Partners (%)
Sept 2025	102	11 (10.8)
Oct 2025	123	7 (5.7)
Nov 2025	87	9 (7.9)
Dec 2025	97	6 (6.1)
Jan 2026	92	6 (6.1)
Feb 2026	111	7 (5.7)
Total	612	46 (7.5)

Source: (MOHCC, 2026)

Table 2 shows that 7.5 % male partners of the women who visited ANC for six months from September 2025 to February 2026 visited the department. Most of them are for the women who would have tested HIV positive during screening and were coming for screening as well from

Lack of Awareness as a Barrier to Attendance

The men were asked what had motivated them to attend ANC, or what had prevented them from going. The results reveal that a lack of awareness was the most prevalent barrier (Table 3).

Table 3: Reasons given for attending or not attending ANC

(N=50)

Reason Given	N	%
Did not know they were expected or welcome at ANC	26	52.0
Encouraged by partner or family members	8	16.0
Wanted to show support for their partner	4	8.0
Other reasons	5	10.0
Curious about the baby (e.g., to find out the sex)	3	6.0
Could not attend due to work	4	8.0
Total	50	100.0

The most common reason men gave for not attending ANC was that they simply did not know they were expected or welcome to go (52.0%, n = 26). This is an important finding because it shows that many men were not making an active choice to stay away, they just were not aware that their presence at ANC was needed or valued. Among those who did attend, the most common reason was being encouraged by their partner or family (16.0%, n = 8), followed by wanting to show support for their partner (8.0%, n = 4). A small number (6.0%, n = 3) attended mainly because they were curious about the baby, for example to find out the sex.

Midwife - "We have not told men that they are invited to be part of ANC. If you look at it, all health education activities and materials always target women. That is why men can come and wait in the car until the wife is served."

Limited Understanding of the Male Role and Responsibility

The male partners were asked whose responsibility they believed ANC attendance to be, the woman, the man, or both. Nearly two thirds of them (64.0%, n = 32) believed that ANC was a woman's responsibility alone whilst a third (36.0%, n = 18) believed it was a shared responsibility for both the man and the woman. It is worth noting that all the men who said ANC was only the woman's responsibility had never attended ANC or had only attended once. This suggests a direct link between how men think about ANC.

Nurse, ANC Unit - "Men here understand their role in pregnancy as providing money and food. That is what a man is supposed to do. Going to the clinic with the wife is not something they see as part of their job. They will say, I am not the one who is pregnant, so why should I sit there? We need to change that thinking."

Perceived Supportive Activities for Male Partners

When asked what activities men could do to support their pregnant partners, most responses fell into three main areas. The most common suggestion was providing financial support, mentioned by about 28.0% (n = 14) of respondents. Helping with physical exercises alongside the partner came second (20.0%, n = 10), and helping with household chores was mentioned by 14.0% (n = 7). Very few men mentioned going to the clinic as a way of supporting their partner. This tells us that many men see their role during pregnancy as mainly financial and domestic, rather than being physically present at health appointments.

Socio-Cultural Barriers - Community Norms and Fear of HIV Testing

Participants were asked how their communities viewed male ANC attendance. Their responses are shown in Figure 2

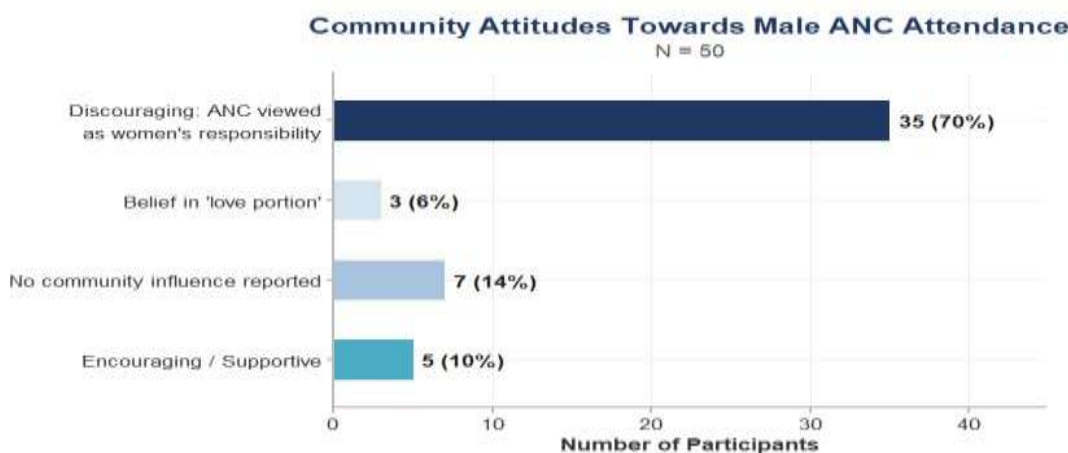


Figure 2: Respondents' Description of Their Community's Attitude Towards Men Attending ANC

Figure 2 makes it clear that most communities in the study area did not support male ANC attendance. A large majority of participants (70.0%, n = 35) said their communities viewed ANC as something only women should do, and that men had no business being there. Only 10.0% (n = 5) lived in communities that were supportive of men attending ANC. Interestingly, 6.0% (n = 3) of participants said their community believed that a man who accompanies his wife to ANC must have been given a 'love portion' — meaning they thought he had been bewitched into going. This type of belief is a strong social barrier because it makes men afraid of being judged or labelled if they attend. Their fears are shown in Figure 3

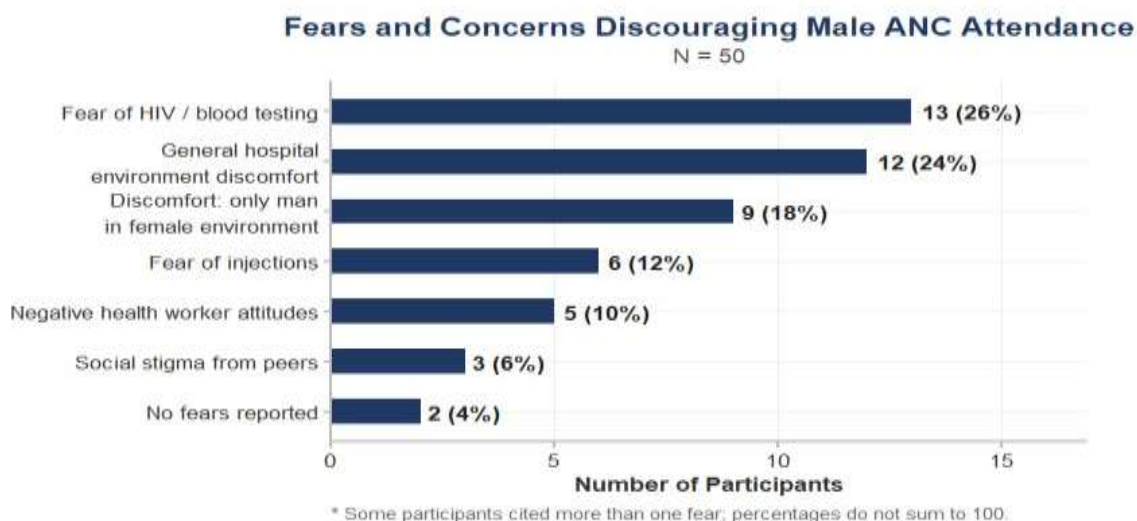


Figure 3: Fears and concerns that discourage men from attending ANC (N=50)

As shown in Figure 3 the fear that came up most often was the fear of being tested for HIV (26.0%, n = 13). Many men were worried about what a positive result would mean for their relationship or their reputation. General discomfort with the clinic environment was also a common concern (24.0%, n = 12), as was the discomfort of being the only man in a room full of pregnant women (18.0%, n = 9). Fear of injections was mentioned by 12.0% (n = 6), and 10.0% (n = 5) were put off by reports of unfriendly or dismissive behaviour from health workers. Only 4.0% (n = 2) said they had no fears at all. the men's responses were verified by the key informants' views.

Midwife - "In this community, if a man goes to the clinic with his wife, people will say he has been given a love portion. They will mock him. No man wants to be labelled like that. It is a very strong cultural belief that ANC belongs to women. Even men who privately want to go are afraid of what their neighbours and workmates will say about them."

Nurse, ANC Unit - "Fear of the HIV test is one of the biggest reasons men refuse to come to ANC. They know that if they come with their wife, they will both be tested so they choose to stay away rather than face that possibility."

Health System and Economic Factors Affecting Male Involvement in ANC

Economic and Work-Related Structural Barriers

The great majority (88.0%, n = 44) of the men claimed that financial or work-related issues was an inhibitory factor for attending ANC with their partners. Their responses are shown in Table 4.

Table 4: Financial and work-related challenges that prevented ANC attendance by men

Challenge Identified	N	%
Work timetable clashes with clinic hours	26	52.0
Cannot afford transport costs for two people	12	24.0
No leave days given for ANC attendance	7-	14.0
General financial difficulties (unemployed or low income)	5	10.0
Total	50	100.0

As Table 4 shows, the most common problem was that men's work hours clashed with clinic opening hours (52.0%, n = 26). This was especially relevant for the men working in the mines, who often work shifts and have very little flexibility. The cost of transport for two people to travel to the clinic and back was also a major issue (24.0%, n = 12), particularly for men who were unemployed or earned a low income. Some participants (14.0%, n = 7) also pointed out that their employers did not give them any leave days specifically for ANC visits, meaning they would lose pay or risk their jobs if they took time off.

ANC Focal Person - "The mining sector is the main employer in Zvishavane and mine workers work on rotating shifts. When we open for ANC, most of those men are underground or just coming off a night shift. The clinic hours and the work schedules are different."

DISCUSSION

The finding that 52.0% of men had never attended ANC is consistent with patterns documented across sub-Saharan Africa. Zvombo et al. (2022) found fewer than 30% of male partners in Harare had ever attended ANC, aligning with the rates in this current study and indicating a persistent national problem. The most striking individual-level finding was that 32.0% of men did not attend simply because they were unaware

they were expected. Tokhi and Comrie-Thomson (2018) identified lack of awareness as one of the most common barriers to male ANC attendance across low- and middle-income countries. The direct association between gender-normative beliefs and non-attendance in this study is consistent with the Health Belief Model which holds that people who do not perceive an action as their responsibility are unlikely to perform it. Nyamai et al. (2022) found the same pattern in Kenya that reframing ANC attendance as responsible fatherhood significantly increased men's willingness to participate. While physical attendance at ANC appointments is an important indicator, male involvement extends beyond clinic attendance and includes financial support, emotional support, participation in decision-making, birth preparedness, childcare planning, and facilitating access to healthcare services. Consequently, low attendance at ANC should not necessarily be interpreted as a complete absence of male involvement.

The socio-cultural barriers identified in this study are well supported by existing regional evidence. The finding that 70.0% of communities viewed ANC as a female domain is consistent with evidence from Zvombo et al., (2022). The love portion belief, though reported by only 6.0% of participants, represents a locally specific stigmatising narrative that Boniphace et al. (2022) argued cannot be addressed through standard health education but requires community dialogue rooted in local cultural understanding. Fear of HIV testing (26.0%) is particularly significant in the high-prevalence Midlands Province setting, where ANC routinely includes couples HIV counselling and testing. Conan et al. (2020), found that men without prior HIV testing history were significantly more likely to avoid ANC specifically because of the testing requirement, a pattern this study confirms in Zvishavane.

Economic and structural barriers in this study align strongly with regional evidence which identified work-related constraints as the most consistent cross-cutting barrier to male ANC attendance across sub-Saharan Africa. Ngunyulu et al. (2021) found specifically that mine workers in Limpopo Province, South Africa were the least likely group to attend maternal health services because of shift-based rosters, the same structural conflict found among the 50.0% of mining employees in this study. Tuyisenge et al. (2021) found in Rwanda that mandated leave for health visits contributed to measurable increases in male ANC attendance nationally.

The findings suggest that male involvement is shaped by the interaction of individual beliefs, gender norms, economic responsibilities, workplace demands, and health-system factors. Rather than acting independently, these influences reinforce one another. For example, cultural expectations that define pregnancy as a woman's responsibility may reduce men's perceived need to attend ANC, while inflexible work schedules and clinic operating hours further limit opportunities for attendance. The clinic hours which clash with men's working hours is a significant and addressable finding. Ongolly and Bukachi (2019) found that extending clinic hours to include Saturdays produced measurable increases in male ANC attendance within three months, and evidence from Tanzania and Rwanda shows that couple-oriented counselling and environmental modifications produce sustained improvements when paired with staff training.

Integration of Quantitative and Qualitative Findings

The integration of quantitative and qualitative findings revealed substantial convergence. Quantitative findings demonstrated very low levels of ANC attendance and identified lack of awareness, socio-cultural norms, economic constraints, and workplace demands as major barriers. These findings were reinforced by qualitative interviews, which provided contextual explanations for the observed patterns. Healthcare workers confirmed that men often perceived ANC as a woman's responsibility, feared HIV testing, and faced difficulties attending clinics because of work commitments. Together, the integrated findings indicate that male attendance at ANC is influenced by interconnected individual, community, and health-system factors rather than any single determinant.

CONCLUSION

The findings suggest that low male attendance is influenced by a combination of individual perceptions, socio-cultural expectations, economic pressures, workplace constraints, and health-system barriers. Although many participants expressed support for their partners during pregnancy, physical attendance at

antenatal care remained limited. Therefore, efforts to improve male involvement should address the complex interaction of these factors rather than focusing on a single barrier. While participants identified several modifiable constraints, further research is required to establish the extent to which removing these barriers would increase antenatal care attendance. With no formal male-involvement programme identified, the men are not aware that their presence is expected thus creating a locally grounded basis for action. Coordinated intervention at policy, health system, and community levels, informed by the barriers and enabling conditions identified in this study, has strong potential to meaningfully improve male ANC involvement in Zvishavane District.

RECOMMENDATIONS

Collaborate between health and labour sectors to introduce statutory paternity leave that explicitly covers ANC attendance to include extending ANC clinic hours to Saturday sessions. In-service training in gender-responsive and male-inclusive communication is mandatory in improving male involvement Training should cover the purposeful acknowledgement of male partners on arrival, their active inclusion during health education sessions and consultations, and respectful engagement that gives men a clear sense of their role at the facility.

Community health workers and village health teams should facilitate structured community dialogues with traditional leaders, religious leaders, and mining employer representatives to reframe ANC attendance as a shared parental responsibility and to challenge stigmatizing.

Conflict of interest

The researchers declare no conflict of interest

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