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RESEARCH ARTICLE

ARE MEN ADEQUATELY INVOLVED IN MATERNAL HEALTHCARE?

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ABSTRACT

The importance of male to women´s sexual and reproductive health promotion was officially recognized by International Conference on Population and Development. Increase male involvement may therefore improve maternal health and reduce maternal morbidity and mortality. The aim of the study was to appraise the involvement of men in antenatal, labour and postpartum care services in different regions of the world. Information was obtained through electronic literature search conducted in PubMed, Medline, and Google scholar, using the following search terms in combination, from 1st January 1992 to 31st December 2015: Male involvement, Maternal healthcare, Nigeria, Developed countries, Developing countries. All relevant peer-reviewed English language articles and publications were identified, retrieved and reviewed. Major findings from the review were analyzed and presented in text. The findings indicated that while there was high level of male involvement with consequent beneficial effects in maternal health in England and USA, the levels of involvement of men in developing nations such as India, Bangladesh, Nepal and Africa are variable with cultural and socioeconomic factors affecting them. The differential level of male involvement in maternal healthcare across different regions of the world underscores the need for health providers and policy makers to evolve couple-centered and male-friendly healthcare services, and also modify factors found to influence male involvement so that maternal health may be improved.

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INTRODUCTION

The importance of male to women´s reproductive health and more generally, in sexual and reproductive health promotion, was officially recognized at the 1994 International Conference on Population and Development in Cairo, and the topic was further elaborated at the Fourth Women's International Conference in Beijing the following year (United Nations Population Fund, 2004). By the turn of the millennium, male involvement –as the approach is commonly called- had begun to get more attention among professionals and program planners in the field (Population Council, 2000). UNFPA in 1995 published a booklet that proposed a new role for men: Instead of being the "threat" that the empowerment programs have to combat, men should be seen as central players in improving women´s status (United Nations Population Fund, 2015). There is no single definition for male involvement. The UNFPA explains male involvement as an umbrella term which comprises of the several aspects of men and reproduction: reproductive health problems and programs, reproductive rights and reproductive behaviour. Furthermore, the UNFPA gives male involvement two dimensions: One, men as supportive partners in women´s reproductive health needs, choices and rights and two, men´s own reproductive and sexual behaviour. Accordingly, male involvement can mean different strategies from education and awareness creation to actual participation. Involving men in reproductive health programs is considered beneficial in many ways, and this perspective has been justified for example through men´s various roles as sexual partners, husbands, fathers, family and household members, community leaders and many times as gatekeepers to health information and services (United Nations Population Fund, 2015). Societal allocation of roles to men and women especially decision making influences utilization of maternal healthcare services. It

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is therefore important for men to understand and appreciate the importance of attendance of ANC and delivery at a health facility. This review was aimed at appraising the involvement of men in antenatal, labour and postpartum care services.

MATERIALS AND METHODS

The information contained in this review was obtained through electronic literature search conducted in major data bases including PubMed, Medline, and Google scholar, using the following search terms in combination, from 1st January 1992 to 31st December 2015: Male involvement, Maternal healthcare, Nigeria, Developed countries, Developing countries. All relevant peer-reviewed English language articles and publications were identified, retrieved and reviewed. Further articles were also obtained by reviewing the bibliographies of the relevant published documents obtained in the primary search of databases. Major findings from the review were analyzed and presented in text.

Review of the literature

For years, data existed only on married women of reproductive age, but for over 10 years or so nationally representative surveys of men aged 15–54 have been carried out in about 40 developing countries (Greene *et al*., 2003). These surveys were undertaken mainly in response to the global challenges created by the HIV/AIDS epidemic, based on an understanding that the epidemic could not be addressed without attention to men. The Demographic and Health Surveys provide a wide range of quantitative information about men's sexual and reproductive knowledge and behaviour, information that can be compared across regions and countries (National Population Commission (NPC) (Nigeria) 2013). Men can affect women's access to prenatal care and women's obstetric outcomes in their roles as partners, neighbours, community leaders, and health providers. In some patriarchal settings, women are not permitted by their husbands or fathers to leave home to obtain care unless accompanied by male family members and unless attended by female health providers (Greene *et al*., 2003). Several studies have evaluated the role of males in maternal healthcare. A search of literature from Pub-Med, Google scholars and other bibliography have reported studies with interesting findings on men's involvement from different parts of the world using different methodologies including intervention studies. A longitudinal study conducted in the United States in 2002 with a sample size of 5404 women and their partners explored the effect of father involvement during prenatal care and maternal smoking (Martin *et al*., 2007). The findings of the study indicated that partners' involvement was high and women whose partners were involved in their pregnancy care were 1.5 times likely to attend prenatal care in the first trimester and smokers reduced smoking by 36% as opposed to those whose partners were not involved in their pregnancy care. A study in rural Guatemala in 2002 also exploring Husbands' involvement in maternal health through individual interviews and focus group discussions reported a relatively desirable and unique involvement of husband in maternal health but rather affected by factors like husband love for the wife, work demands, economic concerns and men's level of knowledge on maternal health (Young and Andreine, 2015). In a study in England (Redshaw, 2013), Over 50% were present for the pregnancy test, for one or more antenatal checks, and almost all were present for ultrasound examinations and for labour. Three-quarters of fathers took paternity leave and, during the postnatal period, most fathers helped with infant care. In the study, greater paternal engagement was positively associated with first contact with health professionals before 12 weeks gestation, having a dating scan, number of antenatal checks, offer and attendance at antenatal classes, and breastfeeding. Paternity leave was also strongly associated with maternal well-being at three months postpartum. In Greece, a cross-sectional study of Greek father's reaction to their presence and participation in baby and child practices explored 4 to 6 weeks postpartum indicated that only 10% of the 157 fathers studied attended the delivery of their spouse and non attendance was attributed to hospital restrictions (Dragonas, 1992). Yet fathers, who were opportuned, reported that their attendance resulted to closer emotional bond with their partners and new born.

A study done in Nepal revealed that husbands accompanied only 40% of their women attending ANC for the first time and that greater decision-making power for women was associated with lower husband accompaniment to ANC and lower overall male involvement (Mullany *et al*., 2007). Other reasons reported for low male involvement in maternal health care is that many men feel marginalized and left outside in their contact with the mother and child care services (Mullany *et al*., 2007). In effect men's involvement in the maternal health care system often stops at the doors to the clinic. To exclude men from the information on the benefits of antenatal care, counseling and services is to ignore the important role male's behaviours and attitudes may play in a woman's maternal health choices. In the same study which was designed to test the impact of involving male partners in antenatal health education on maternal health care utilization and birth preparedness, four hundred and forty two (442) women seeking antenatal services during second trimester of pregnancy were randomized into three groups: women who received education with their husbands, women who received education alone and women who received no education. The education intervention consisted of two 35-minutes health education and these women were followed until after delivery. Women who received education with husbands were more likely to make more than 3 birth preparations and also attend a post-partum visit than women who received education alone or no education. The results revealed that educating pregnant women and their male partners yielded a greater net impact on maternal health behaviours compared with educating women alone. Results from this observation study suggest that including men in reproductive health interventions can enhance positive health outcomes and increased service utilization. Still in Nepal, another study conducted in Kathmandu in 2006 which explored opinions of couples and health workers on the understanding on the barriers of male involvement in maternal health unfolded that some of the barriers that prevent men from participating in maternal health includes low level of knowledge, social stigma, shyness and embarrassment, job responsibility, space problem, non couple friendly maternal health services and hospital policy restrictions (Barker, 2000). Furthermore, hospital policy restrictions are factors that have been known to impede men's participation in labour. In a

qualitative study conducted in Bangladesh through focus group discussions to explore why are men not participating in reproductive health services (Shahjahan and Kabir, 2006), findings indicated that men are not motivated and traditionally not encouraged to participate in reproductive health services. Other factors like poor husband-wife interaction which makes it difficult for men to understand reproductive problems of women, unmet men reproductive health needs, men's discomfort to visit clinics with their wives because of cultural myths and men's discomfort to discuss reproductive health issues with service providers were also identified. A study was conducted in India on men's involvement during pregnancy and childbirth (Abhishek and Faujdar, 2009). The objective of the study was to gain a quantitative insight on the subject; primary data collected from men aged 15-54 years was used to examine men's involvement during pregnancy and childbirth. The indicators of men's involvement were designed to measure presence of men during antenatal visits and child birth, type of assistance provided during pregnancy, and men's involvement in deciding the place of delivery and the person to conduct the delivery. The study used a measure of social network and gender role attitudes in explaining men's involvement during pregnancy and childbirth in India. The results revealed that a substantial proportion of men were involved during pregnancy and childbirth in rural India. Gender role attitudes and social network are important predictors of men's involvement during pregnancy and childbirth.

Another intervention study conducted in Andhra Pradesh in rural India in 2004-2006 aimed at improving maternal health outcome and pregnancy related care by building support for pregnant women to access health care services through involvement of the family especially the husband, also indicated an increased use of Government health facilities and increase in institutional deliveries (Dipa, 2008). Women also reported being accompanied by husbands and mothers to access antenatal care more, consuming more nutritious diet and reduction in their work load. A number of studies have also been conducted in Africa. A study on men's involvement in South African family entitled engendering change in the AIDS Era explored the range of roles played by whole house hold members including men using participant observation of 20 house-holds caring for at least one adult with disease symptom indicative of tuberculosis or AIDS and data was also examine from a small sample of house hold affected by HIV and AIDS in rural Kwazulu for two and half years (Pile *et al*., 2015). The findings of this study indicated that men are positively involved with their families and household in a wide range of ways, thus caring for patients and children, giving financial support and their presence and support at home permit the woman to be able to engage on other house hold work. Conversely, the same study has also demonstrated that such activities are not acknowledged and the dominant perception of both female respondents and research assistant continue to be that men are not caring for their families and are profligate. Another study was conducted by Mullick, Busi & Wanjiru on involving men in maternity care (Mullick *et al*., 2005). In this study, Reproductive Health Research Unit of Witwatersrand University, in partnership with the FRONTIERS Program of Population Council and the KwaZulu-Natal Department of Health, began a three-year operations research study, to incorporate men in their partners' maternity care, in order to improve couples' reproductive health and pregnancy outcomes. The study showed that it was indeed acceptable and feasible to involve men in the reproductive health care of their partners. Both men and women were interested in men's involvement during maternity care. However, there remain a number of health service delivery challenges that need to be addressed within the South African context before maternity services become more male friendly.

In two rural clinics in Tanzania, a study aimed at describing the prevalence and predictors of male partner participation in HIV voluntary counselling and testing and the effect of partner participation and uptake of HIV prenatal intervention was conducted (Msuya *et al*., 2008). The findings indicated that sero-positive mothers whose partners attended voluntary counselling and testing after being encouraged to inform and invite their partners were 3 times more likely to use Nevirapine prophylaxis, 4 times more likely to avoid breast feeding and 6 times more likely to adhere to the feeding method selected than those whose partners did not attend. A study in Northern Uganda investigated the level, perceived benefits and factors associated with male partner attendance of skilled ANC in a peri-urban community (Tweheyo *et al*., 2010). This cross-sectional survey used multi-stage sampling in 12 villages of Omoro county to select 331 married male respondents aged 18 years or more, whose female spouses had childbirth within 24 months prior to the survey. A structured questionnaire elicited responses about male partner attendance of ANC during pregnancy at a public health facility as the main outcome variable. Overall, 65.4% male partners attended at least one skilled ANC visit. Men who were knowledgeable of ANC services, obtained health information from a health worker and whose spouses utilised skilled delivery at last pregnancy were more likely to accompany their spouses at ANC, unlike those who wanted to have more children and lived more than 5 km from the health facility. These findings suggest that empowering male partners with knowledge about ANC services may increase their ANC participation and in turn increase skilled delivery. This strategy may improve maternal health care. In Nigeria, studies on the participation of men in maternal care have been reported from southern and north-western parts (Olugbenga-Bello *et al*., 2013; Morhason-Bello *et al*., 2008; Adamu and Salihu, 2002; Iliyasu *et al*., 2010). Olugbenga *et al*. (2013) reported that only 20% of men accompanied their wives to antenatal clinics in spite the very high knowledge of its importance among them, in Osun, Southwest Nigeria. Likewise, Morhason-Bello *et al*. (2008) reported that 86% of antenatal clients in University College Hospital, Ibadan, preferred their husbands as companions during labour while only 7% and 5% favoured their mothers and siblings respectively. In Kano Northwest Nigeria (Adamu and Salihu, 2002), 17.2 % of women did not attend regular ANC because of husband denial. In the same region, Ilyasu *et al*. (2010), discovered that only 18.7% of men personally accompany their spouses to the hospital with only 3.7% donating blood, but when complications occurred, the proportion of respondents that accompanied their wives rose significantly to 33.9% with a higher proportion (15.2%) also donating blood (Iliyasu et. al., 2010). The same study indicated that only 12% of men will personally accompany their wives to

postnatal clinic but more than 80% of them will provide money for transportation and drugs. In Maiduguri Northeast Nigeria, an unpublished study conducted by Ibrahim *et al*. (2015) in the capital city showed that the proportion of husbands involved in maternal health care was high. In the study, a multistage sampling technique was used to select 22 households from each of 14 wards from 3 districts, and pre-tested structured researcher-administered questionnaires, which was designed using a set of questions synthesized from USAID Compendium of Indicators for Evaluating Reproductive Health Programs (Bertrand and Escudero, 2002), and Health Belief Model of Health Behavioural Change Theory (Rosenstock, 1996) were used to collect data from married men. The result showed that 73.3 % of husbands were involved in ANC, 69.4% in labour and 56.4 % in postnatal care. It was also discovered that factors such as higher educational status, having means of transportation, making joint decision on issues of ANC as couples, ANC facility with good condition of services and spending less than 30 minutes waiting time for consultation were highly predictive of husbands' involvement in maternal health care.

Conclusion

Considering the variable levels of male involvement in maternal healthcare across different regions of the world and a number of factors that have been reported by several researchers as being responsible for influencing male involvement, health providers and policy makers must deviate from hitherto exclusive women-centered programme planning and services, especially with regards to promotion of safe motherhood, to couple-centered and male friendly healthcare services. Factors known to influence male involvement should be modified to improve their involvement.

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