Original Article

Spousal Participation During Pregnancy and Delivery in Ilorin, Nigeria

Abiodun S. Adeniran[1], Adegboyega A. Fawole[1,2], Kikelomo T. Adesina[1], Abiodun P. Aboyeji[1,4], Olayinka R. Balogun[1,3], Munirdeen A. Ijaiya[1]

[1]Department of Obstetrics & Gynaecology, University of Ilorin/ University of Ilorin Teaching Hospital, Ilorin, Nigeria.

[2]Anchormed Hospital, Ilorin, Nigeria, [3]Surulere Medical Centre, Ilorin, Nigeria, [4]Royalcare Hospital, Ilorin, Nigeria

ABSTRACT

Background: The potential benefits of the active involvement of men in antenatal and intrapartum events remain largely unexplored in low-resource countries despite the reported benefits from high-income areas.

Aim: To evaluate male partners' attitudes and experience on their level of involvement during pregnancy, labour and delivery.

Methods: A cross-sectional study conducted at four health facilities in North Central Nigeria from 1st February to 30th July 2017. Participants were male partners of women who were pregnant during the study period; recruitment was after informed consent, data management was with SPSS (version 21.0); $p < 0.05$ was significant.

Results: The male partners were aged 23 to 60 years (mean 35.96±6.76), 173 (69.2%) accompanied the partner to antenatal clinic and 150(60.0%) to ultrasound scan examination. The commonest hindrance to men's antenatal participation was commuter marriage (29; 37.7%); 171(68.4%) participants supported the presence of the man at delivery while 32(40.5%) opined that men may disturb the health provider during delivery. Also, 137(54.8%) men have requested to be present at delivery previously while 46(33.6%) were obliged; among those obliged, 25(54.3%) described the experience as satisfactory while 28(60.9%) intend to be present at future deliveries. In all, 212(84.8%) suggested antepartum education classes for male partners, 202(80.8%) intend to attend such classes while 143(57.2%) suggested health facility restructuring to facilitate men's participation.

Conclusion: Men are increasingly desirous of active participation at antenatal and intrapartum events; increasing male partner education, male-friendly facility infrastructures and health providers' cooperation will encourage them to fulfil these roles.

INTRODUCTION

The role of men in women's health especially maternal health is receiving an increasing attention globally and has been linked to the pregnancy outcomes. Men's support has been linked to women's ability to seek care and implement lessons learned at hospitals especially in low-income settings.[1] It also reduces maternal stress and negative health behaviours during pregnancy thereby improving feto-maternal outcome.[2] Attendance at antenatal clinic sessions was reported to be higher in parturient with partner participation in their care;[3] Male partner participation is widely accepted and practiced in high-income countries. In a report from America, 98% of men attended the baby's birth, 48% attended antenatal/parenting classes, 85% at least one prenatal appointment and 86% at least one ultrasound examination.[4]

Corresponding author:
Abiodun Adeniran,
Department of Obstetrics & Gynaecology,
University of Ilorin, PMB 1515, Ilorin, Nigeria.
E-mail: acrowncord@hotmail.com
Tel: +2324 8057534788

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Most low-income countries are patriarchal and the male partner is responsible for decision making on when and where to seek medical care by the family members.[5] Thus, their disapproval have hindered health care service uptake by family members. In addition, women in these countries have been reported to show an increasing desire for the partners' involvement in pregnancy and delivery events[6] while the men are becoming increasingly interested in the events.[7]

Low-income countries contribute significantly to global poor pregnancy outcomes; therefore, an intervention that may assist in reducing these poor outcomes is desirable. Male partner participation which has been shown to be beneficial in high-income countries could be explored for its potential benefits in low-income areas. The study aimed to explore the attitude and experiences of the male partners on their participation during pregnancy, labour and delivery in a low resource community.

METHODS

The study was a cross-sectional survey conducted in Ilorin, North Central Nigeria from 1st February to 31st July 2017. There were four study sites comprising one tertiary and three obstetrician-supervised private hospitals; all sites had facilities and manpower for obstetric services including caesarean delivery. All the study sites have multiple-bedded delivery rooms while two facilities routinely allow male partners at labour and delivery.

Participants were male partners of women who were pregnant during the study period.

The inclusion criteria for participants included adult males legally or socially responsible for the index pregnancy who gave consent for participation.

Other males including relatives or associates who were not legally or socially responsible for the index pregnancy as well as male partners who decline to participate in the study were excluded from the study.

The sample size was calculated using the formula for cross-sectional study,[8] the reported prevalence of 14.2%[6] male partner involvement in pregnancy and delivery in the study area, 95% confidence interval, degree of accuracy of 0.05 and 20% attrition rate to give a minimum sample size of 224 participants.

The sampling method was purposive sampling with recruitment of consenting eligible participants until the sample size was completed.

Study protocol

The study was facility-based; thus, all adult males who presented at the study sites during the study period were screened to determine their eligibility (i.e. partner must be pregnant at time of recruitment). The men were informed about the study using the participant information sheet and an informed consent obtained. Recruitment for the study was at all hospital service points including presentation for consultation by the man for his health or that of any family member, men who accompanied the woman to antenatal clinic or during labour and delivery. The tool for data collection was a structured interviewer-administered questionnaire which was completed by trained interviewers. The questionnaire was developed using the research questions and reports from previous studies; pretesting was among male partners of pregnant women in two facilities in another locality.

Ethical approval was obtained from the ethical review committee of the tertiary hospital before the commencement of the study and informed consent was obtained from all participants.

Key variables in the study and definition of the variables:

The key variables in the study were the pattern of home setting (couple living together or commuter marriage), attitude and experience of male partners towards participation in antenatal, labour and delivery events as well as previous participation or request to be present at labour and delivery. The definitions of the key variables in the study are as follows:

Male partner: an adult male who was legally or socially responsible for the index pregnancy.

Commuter marriage: a marriage in which one of the partners resides in another locality with interval

visits to the partner living at the study area.

Presence in labour and delivery events: physical presence of male partner in the labour room during the labour and delivery.

Data analysis

Statistical analysis was done with SPSS version 21.0, the Pearson's chi square was used for comparison and representation in tables while p value <0.05 was termed significant.

RESULTS

There were 250 participating men aged 23 to 60 years (mean 35.9±6.7), 231 (92.4%) were in monogamous marriages while 244 (97.6%) had at least primary level of education as shown in table1. Table 2 shows that 173(69.2%) followed the partner to antenatal clinic visit and 150 (60.0%) were present at ultrasound evaluation of the fetus. Commuter marriage (29; 37.7%) was the commonest reason for male non-participation in antenatal events, 212(84.8%) suggested male antepartum education classes while 202(80.8%) were willing to attend such classes. The role of men during labour and delivery was the commonest anticipated topic for discussion (92; 43.4%) at the class as shown in table 2.

Table 3 shows that 171(68.4%) participants supported male partner's presence at labour and delivery to enhance appreciation of the value of women (95; 55.6%) or encourage the women in labour (54;31.6%). Also, 137(54.8%) men have requested to be present at previous delivery; 46(33.6%) were obliged among who 25(54.3%) were satisfied with the experience while 28(60.9) desire to be present at future deliveries. About half (143; 57.2%) suggest health facility restructuring to encourage men's participation.

Table 4 shows that the man's presence at previous delivery of the partner was significantly associated with support for male partner's presence at delivery (p0.003). However, paternal age (p0.674), number of wives (p0.766) as well as presence at antenatal clinic visit (p0.169) or ultrasound evaluation (p0.345) was not significant.

Table 1: Bio-social characteristics of participating male partners

Variable	Frequency (N = 250)	Percent
Age range (years)	23 – 60	
Mean age ± SD (years)	35.96 ± 6.76	
Age group (years)		
≤30	53	21.2
31 – 40	148	59.2
41 – 50	41	16.4
51 – 60	8	3.2
Employment status		
Employed	134	53.6
Self employed	91	36.4
Unemployed	25	10.0
Number of wives		
1	231	92.4
2	16	6.4
3	3	1.2
Educational status		
None	6	2.4
Primary	11	4.4
Secondary	46	18.4
Tertiary	187	74.8

Table 2: Antenatal participation among the male partners

Variable	Frequency	Percent
Ever followed wife to antenatal		
Yes	173	69.2
No	77	30.8
Reasons for not following (n = 77)		
I work in another town	29	37.7
It is not the custom	12	15.6
I will rather go and get money for the family	9	11.7
I will feel ashamed	9	11.7
She can take care of herself	14	18.2
It is a Woman affair	4	5.2
Would follow wife on request		
Yes	219	87.6
No	31	12.4
Followed wife for ultrasound scan		
Yes	150	60.0
No	100	40.0
It is necessary to have a class to educate husbands		
Yes	212	84.8
No	38	15.2
What men should be taught (n = 212)*		
Effect of pregnancy on the woman	80	37.7
Sexual intercourse during pregnancy	54	25.5
Role of men during labor/ delivery	92	43.4
Family planning	52	24.5
Willingness to attend such class		
Yes	202	80.8
No	48	19.2

*: Multiple responses allowed

Table 3: Intrapartum participation and limitations among the male partners

Variable	Frequency	Percent
Men should be allowed to stay with their wives during delivery		
Yes	171	68.4
No	79	31.6
Reasons why men should stay (n = 171)*		
To know how painful it is	50	29.2
To treat women better	33	19.3
Make men allow family planning	13	7.6
To encourage women in labour	54	31.6
To appreciate the value of women	95	55.6
To like the child better	7	4.1
It will stop extra marital affairs	8	4.7
To increase love in the home	35	20.5
Reasons why men should not be allowed to stay (n =79)*		
Delivery is sacred for women only	18	22.8
The man will feel ashamed	4	5.1
It will make the wife not to push well	9	11.4
Men may disturb the doctors/ nurses	32	40.5
Men may collapse and faint	17	21.5
Men may cry	14	7.7
Men have no role to play	13	16.5
Ever requested to be with partner during labour/delivery	137	54.8
Yes	113	45.2
No		
Request to stay with the partner was granted (n=137)	46	33.6
Yes	91	66.4
No		
Experience following presence with partner in labour/ delivery	1	2.2
I was afraid the baby might die	4	8.7
I collapsed during the delivery	16	34.8
I was afraid that my partner might die	25	54.3
I was happy and satisfied		
Will you like to be present at next delivery? (n=46)	28	60.9
Yes	18	39.1
No		
Infrastructural restructuring will improve male participation	143	57.2
Yes	107	42.8
No		

***: Multiple responses allowed**

Table 4: Determinants of opinion on intrapartum presence of the male partners

Variable	Yes n = 171 (%)	No n = 79 (%)	χ^2	*p* value
Age group (years)				
≤ 30	33 (62.3)	20 (37.7)	1.535	0.674
31 – 40	102 (68.9)	46 (31.1)		
41 – 50	30 (73.2)	11 (26.8)		
51 – 60	6 (75.0)	2 (25.0)		
Employment status				
Employed	97 (72.4)	37 (27.6)	2.337	0.311
Self employed	59 (64.8)	32 (35.2)		
Unemployed	15 (60.0)	10 (40.0)		
Number of wives				
1	159 (68.8)	72 (31.2)	0.532	0.766
2	11 (68.8)	5 (31.3)		
3	1 (33.3)	2 (66.7)		
Educational status				
None	2 (33.3)	4 (66.7)	4.026	0.258
Primary	5 (45.5)	6 (54.5)		
Secondary	32 (69.6)	14 (30.4)		
Tertiary	132 (70.6)	55 (29.4)		
Ever followed wife for antenatal				
Yes	123 (71.1)	50 (28.9)	1.892	0.169
No	48 (62.3)	29 (37.7)		
Present at ultrasound scan				
Yes	106 (70.7)	44 (29.3)	0.891	0.345
No	65 (65.0)	35 (35.0)		
Previously requested for intrapartum participation				
Yes	97 (70.8)	40 (29.2)	0.810	0.368
No	74 (65.5)	39(34.5)		
Previously intrapartum participation				
Yes	40 (87.0)	6 (13.0)	8.741	0.003
No	57(62.6)	34 (37.4)		

χ^2: Chi square

DISCUSSION

From this study most men accompanied the partners to antenatal clinic or were present at ultrasound scan; reasons for limited male involvement in the antenatal period were commuter marriage and cultural reasons. Most men desire the establishment of antenatal education classes for the male partner and the suggested topics for discussion include the role of men during labour and delivery, effect of pregnancy on the woman and sexual intercourse during pregnancy. Participants opined that their participation during labour and delivery will make men to appreciate the value of women, encourage the partner and encourage contraception. The common reasons for men's absence were fear of interference with the duties of the birth attendant as

well as cultural reasons. Most men who were present at previous deliveries described the experience as satisfactory and desire to be present in the future.

The antenatal participation of male partners in this study with 69.2% accompanying the woman to antenatal clinic visit was higher than reports of 42%[9] in Nigeria and 42.9%[10] in Uganda but lower than 82%[11] in India. However, the Nigeria study was earlier, thus the higher percentage may be a reflection of the current global trend of increasing male participation.[6] Also, the lower percentage in the Uganda study may because the study was among rural dwellers compared to urban dwellers in this study. However, the high presence of male partner at ultrasonography could be due to the interest in knowing the fetal gender.[12] Work-related and cultural challenges are recognised hindrances to men's antenatal involvement from this study. Many men work away from home leading to commuter marriages while others need permission from superiors to be able to accompany the woman to hospital[11] such that while the request by a woman to be off-work to attend antenatal clinic is considered as necessary unlike the male partner's. This raises concerns for the policy to institutionalize permission for the male partner to perform this supportive role.

Reported advantages of the men's presence at delivery include the opportunity to be the first to welcome the newborn, understand the birthing process or act as advocates to request for interventions including labour analgesia.[13-15] The motivations for men's intrapartum involvement include their partners,[5,14] peers and sheer curiosity.[14] Also, women have been reported to feel more in control of the birth process and feel secured when their partners were present.[15] A study from Malawi reported that men who were present at the partner's delivery had an improved knowledge of women's health, were more protective of the children and willing to tolerate longer period before resuming sex postpartum especially when episiotomy was used. The experience of men who were present at the partner's delivery varies; however, similar to this study, previous reports described the experience as satisfactory[16,17] with a desire to attend future births. It has been suggested that health workers tend to underestimate the psychological boost men give to their partners during delivery as well as the practical support they offer.[18]

The major challenge especially in low resource countries to men's participation at delivery is health-system related. These include birth attendants' refusal of the men's requests due to the impression that men will disturb these attendants in addition to the unfriendly delivery infrastructures.[3,5,6,19] Most hospitals in low resource countries have open labour wards accommodating many women simultaneously for delivery unlike cubicles in high-income countries. In a study among birth attendants in Nigeria, 37.1% granted the male partner's request to be at delivery; the major reasons for refusal were the view that men will disturb (60.4%) and the fear of litigation (23.6%).[19] However, only 11% birth attendants reported that the male partners interfered with their work while 2.4% reported litigations in the study.[19] This suggests that there may have been an overestimation of the fears for refusing men's presence at delivery. There are concerns about the negative effect of the labour experience on the male partner. In a report, there was no effect of negative birthing process on depressive symptoms in fathers at six weeks postpartum when correction was made for pre-existing depressive symptoms.[20] Men's participation in pregnancy events can be sustained through infrastructural restructuring at the antenatal clinics and delivery wards[3,5,19] to ensure privacy as well as staff orientation towards respectful maternity services.[3]

There has been suggestion to establish antenatal health education programs for awaiting fathers during antenatal period. Antenatal health education services no doubt has the potential to improve pregnancy outcome but the woman's ability to implement lessons learnt has been shown to depend on the man as household head. It was reported that women who received antenatal health education

with the partner were more likely to embrace health seeking behaviour afterwards and attend postnatal clinic.[21] In India, it was reported that antenatal education for prospective fathers resulted in increased antenatal attendance by the woman irrespective of the couple's social class.[22] Participants in this study support such male education programs and desire discussions on men's role during labour and delivery, effect of pregnancy on the woman, sexual intercourse during pregnancy and contraception. However, the positive influence of spousal support is not limited to pregnancy outcome; it has been reported to lead to increased female uptake and compliance with contraception among women in Nigeria.[23] In sub-Saharan Africa, awareness campaigns have been recommended to encourage acceptance of male antenatal education programs in women-related health issues.[3,6] For example, joint HIV counselling and testing for couples at the antenatal clinic has the potential to encourage wider testing, partner notification of the test result, partner support for antiretroviral therapy and safe sex-practices.[3] This will by extension yield a communal and eventual global advantage in the fight against HIV/AIDS pandemic.

In conclusion, this study suggests that men are increasingly desirous of involvement at antenatal and intrapartum events. Therefore, antenatal male education, male-friendly facility infrastructures and positive health providers' attitude will contribute positively to achieve the potential benefits.

Strength and limitations

The strength of the study in evaluating male partners who are not easily accessible in low resource countries because they are more often absent at health facilities. The limitations include restriction of the geographical spread of the study to urban dwellers and the hospital-based design. Thus, men in the rural areas and those who did not visit the health facility during the study period were excluded from the study due to its design; a community-based study would have reflected the experience of such men.

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Criteria for inclusion in authors' list: ASA conceived the idea; all authors participated in proposal drafting, data collection and manuscript writing.

All authors read and approved the manuscript and met authorship criteria.

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