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Involving men in maternity care: health service delivery issues

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abstract

Men in South Africa have traditionally not been involved in the reproductive health care of their partners. They do not normally accompany their partners to family planning or antenatal care consultations, and are mostly absent during labour and delivery. Partner notification and treatment for sexually transmitted infections have also remained problematic due to several factors, including poor power relations between men and women, lack of knowledge and men's interest in their partner's reproductive health, and poor couple communication.

In 2001, the Reproductive Health Research Unit (RHRU) 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.

This 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.

keywords

maternity care, pregnancy, men, couples counselling

Background

In South Africa, as in most other African countries, family planning, pregnancy and childbirth have long been regarded as exclusively women's affairs. Men generally do not accompany their partners to family planning, antenatal or postnatal care services and are not expected to attend the labour or birth of their children. However, male dominance socially and in sexual relations can put women at serious risk of unwanted pregnancy and infection; in pregnancy, male sexual behaviour can affect the health outcomes of both mother and baby. Their lack of participation at family planning, antenatal and postnatal consultations means that they do not benefit from any information given by health providers, regarding the health of mother and baby, or about their role in it.

In addition, men are rarely exposed to clinic reproductive health services as they tend to seek care for sexually transmitted infections (STIs) in the private sector, and condoms can be obtained from clinics without contact with providers. The issue of accessibility of reproductive health (RH) services to men in South Africa is a logistical and cultural problem. The exclusive use of services by women has, to a great extent, made RH services unfriendly for men.

In South Africa, the lack of services designed to involve men in fertility regulation or reproductive choice, was identified in 1994

in an assessment of reproductive health services (Reproductive Health Task Force, 1994). Tsui et al (1997) state that with respect to obstetric care, it is often the family, and not the woman alone, who makes decisions. They further stress that men are the obvious target audience because, in many cases, they control the cash reserves or their permission needs to be obtained for obstetric care-seeking (Dallabetta et al, 1997). Men may also be seen as the principal vectors of their partners' sexual health regarding STIs. Not uncommonly, women who perceive themselves to be in a monogamous relationship are at risk of infection because of their partners' sexual relationships with other women.

Involving men in the maternity care of their pregnant partners has become important because of the realisation that men's behaviour can significantly affect the health outcomes of the women and babies. Men have increasingly become aware of their critical role in reproductive health care. In South Africa, high rates of STIs and HIV/AIDS, significant rates of maternal mortality as well as high rates of unemployment amongst women, make involving men especially important. In the past, men have been excluded from maternity care due to the influence of traditional culture, and a number of factors centred around health service delivery issues.

Men in Maternity Care study

Over the last three years, a health service-based intervention, known as the Men in Maternity Care study (MiM), was implemented in KwaZulu-Natal (KZN), and evaluated to establish whether it was feasible to involve men in antenatal and postnatal care, and whether this would be acceptable to health care providers, the clients and their partners. The research study was also designed to establish how effective the expanded antenatal and postnatal care programme would be, for improving the reproductive health of both women and the men, especially for increasing the use of postpartum family planning, improving behaviours that protect against STI and HIV/AIDS infection, increasing recognition of danger signs that could potentially lead to maternal mortality and improving partner communication and support.

KZN has a population of 9.1 million people, with over half (57%) living in rural areas (Editors Inc, 2004). The literacy rate for the province was reported as 89%, which is above the national rate of 85% (Reproductive Rights Alliance, 2003). Eighty-one percent of the population is African, mainly Zulu-speaking, with strong cultural beliefs around the role of men in antenatal and postnatal care. Men are culturally not expected to be involved in maternity-related issues. Even if men want to be involved in maternity care, societal and health system norms often mitigate against this. The HIV prevalence rate among antenatal clients in KZN was 33.5% in 2002 (Department of Health, 2003) and the maternal mortality rate increased from 188/100 000 in 1998 to 243/100 000 in 2001, with 23% of these deaths being HIV-related (Department of Health, 2001).

In the Zulu-speaking community, as in many other African communities, a man is viewed as a ruler and protector of his household. His 'proper' sphere of action is economic and political. He is viewed as the head of the family proper and is, therefore, expected to provide; at the same time, he is entitled to use his resources as he chooses. The concept of being a 'real' man in this community is strong and, therefore, men are not expected to admit uncertainty. Some risky sexual behaviours are even associated with being 'manly'. This could compromise their health as well as that of their partners (Peacock, 2003). These are some of the reasons given for men's perceived lack of emotional involvement

in their relationships.

In the health sector, even though some men have started to be involved in antenatal care, they still attend these services as partners and are 'tolerated' as such. Even in places where men are involved in maternity care, the focus is not on men; little attention is given to the relationship between father and baby and little information is provided on topics relevant to men. Reproductive health providers and planners often think of women as 'exclusive users' of maternity and other reproductive health services. Even the health messages are directed at women, and despite the common interest in the child, men are not engaged and assisted to become responsible parents.

When the MiM study started in March 2001, the local health providers were initially sceptical about the success of its activities. In Zulu culture, it was previously unheard of for men to be involved in the care of their infant children; they are not permitted to see the mother or child for three months after the birth because this is thought to make the males 'weak'. One nurse said that she thought the community would be against the study because it 'violated African rights'. Another recalled how shocked she was when she saw a man bringing a baby to the clinic to get immunised, a few years ago. She immediately thought something terrible had happened and demanded to know where the mother was. After several meetings and discussions with the MiM research team, the nurses began to see the advantages of involving men, and eventually it was these nurses who were trying to convince the obstetricians and gynaecologists to support the project.

Little attention is given to the relationship between father and baby

The study was conducted in eight urban and four rural clinics that fell in the administrative area of the Prince Mshiyeni Memorial Hospital (PMMH). The hospital is located in Umlazi township which, with a population of about two million, is the largest township in the Durban metropolitan area and the second largest township in South Africa. This tertiary hospital has 22 clinics under its administration, almost all providing antenatal care services. Since 1992, due to political unrest and security issues, the clinics have discontinued birthing services, and today, most women deliver in the hospital, which now attends 12 000 deliveries each year. Antenatal care services in the clinics are provided by registered nurse-midwives with doctors only available at the hospital.

This *article* discusses some of the health service delivery issues raised by maternity care health service providers, clients and their partners in the course of the MiM study. Specifically, the *article* aims to discuss:

- provider and client views or perspectives about male involvement during maternity;
- providers' motivational factors;
- lessons learnt;
- opportunities identified; and
- recommendations and implications.[1]

Methodology

In preparation for the project, qualitative data was collected from groups of stakeholders to obtain input which would help in the design of the intervention and provide information on acceptability and feasibility.

At baseline, 2 082 women (1 087 control and 995 intervention) and 584 male partners of the women in the intervention group were interviewed with a structured questionnaire being used. A follow-up rate of 68% was achieved for women, and 80% of their partners were interviewed in both control and intervention sites.

Eleven focus group discussions were conducted with pregnant women, men whose partners were pregnant at that time, and

couples who had recently had babies. Three focus group discussions were conducted with each of the above groups consisting of 6-12 participants.

Themes that were explored included perceptions on the benefits of maternal health care services, and community attitudes towards partner involvement were also assessed.

The activities that the project introduced were divided into two broad categories, one aimed at improving the existing antenatal services and the other aimed at integrating a new component, ie the introduction of couples counselling during the antenatal and postnatal care period.

The couples counselling was introduced through:

- training providers in couples counselling;
- developing an antenatal care booklet and leaflet for couples;
- inviting partners verbally and in writing;
- counselling individuals and couples; and
- continuous support and mentoring.

At the end of the project, three focus group discussions were held with the six intervention clinics to assess the provider satisfaction with the intervention. Each category of staff (person in charge, registered midwives and assistant nurses) had their own focus group discussion (of six participants) to ensure homogeneity of the group. Most of the nurses had worked in antenatal care for more than five years. Structured questionnaires were also used to interview women and their partners at six months postpartum.

Characteristics

The characteristics of the control and intervention groups are shown in table 1. The data presented on men consists of responses given by women about their partners for selected characteristics (age, education, literacy and employment status). Men were similar in their characteristics in both intervention and control groups. The majority of men were employed and could read a local language and

Table 1: Socio-demographic characteristics of the participants

Characteristic	Control % (n=1087)		Intervention % (n=995)	
	Women	Men	Women	Men
Age				
Mean age (years)	23 (sd* 5.97)	28(sd 7.11)	24(sd 6.47)	28(sd 7.4)
Relationship status				
Regular 'visiting' relationship	66		64	
Not married , living together	24		26	
Married, living together	7		9	
Married, living apart	1		1	
Broken up/not together	2		0	
Literacy				
Writes	99	97	97	97
Reads local language	97	96	95	96
Reads English	85	92	78	87
Employment Status				
Unemployed	86	18	87	21
Employed full/part time	14	82	13	79

sd = standard deviation

English. Only around a quarter of both control and intervention groups were living together.

This was confirmed in the quantitative interviews in which women and men responded positively to involving their partners in a number of proposed activities.[2]

Involvement of partners during maternity

Both women and men responded positively to involving or being involved with their partners in maternity health in a number of proposed activities (table 2). All the groups were less likely to want their partners at delivery (66% control, 72% intervention) compared to other activities such as being accompanied to postpartum visits (94% control, 97% intervention). Men were generally in agreement with women in respect of clinic-based activities, such as accompanying women to the clinic and to postpartum visits. Men were slightly less willing to be part of consultations and group discussions, and even less willing in areas such as labour (69%) and delivery (53%).

Women's perspectives

Women expressed a desire for their partners to become involved in all areas of pregnancy so they could understand the process; this was also confirmed in the quantitative results.

Women indicated that nurses would then be able to communicate directly and provide health education to their partners. They also felt that they would benefit indirectly: 'Men will learn how to treat us. They will treat us like ladies,' said one woman. Some viewed the intervention as a form of protection from the nurses: 'Nurses will stop harassing us when men get involved in maternity care,' said one woman. Even though women expressed a desire to have their partners involved, not all were enthusiastic. An older woman expressed concern: '… he is going to say why now… I've had babies without him …'

Women were asked their opinions on what stage partners should be involved in maternity care. Several stages were agreed upon by all women: antenatal care, labour and postnatal care. However, some were not sure whether men should be present in the delivery rooms. One concerned woman said: 'According to our custom men become "weak" if they witness the birth of a baby.' Another woman indicated that the presence of men during delivery was even more important: 'It is important for men to be there during delivery so that they can see how we suffer in labour ward.' Most women agreed with this view.

Table 2: involvement of partners in proposed maternal activities

Type of activity	Control	Intervention	
	women % (n=1087)	women % (n=995)	men % (n=584)
Accompany her to postpartum visits	94	97	91
Accompany her to the clinic	87	92	89
Accompany her to consultations/counselling	86	94	87
Be with her in group discussion	82	93	83
Be with her during labour	75	77	69
Accompany to family planning clinic	72	82	71
Be with her during delivery	66	72	53

Men's perspectives

Men also expressed interest and willingness to get involved with pregnancy and to attend couples counselling. Some indicated that although they did generally accompany their partners to the clinic, they normally waited outside. Men said that they did not know what was done or said at the clinics, and that being involved in couples counselling would help them gain this information. One participant said: 'At least we will know what is going on at the clinic.' Men admitted that they lacked knowledge because their partners did not tell them what they learnt from the clinics. One commented that 'women do not tell us what has been said at the clinic and they do not bother to ask us to accompany them (women) to the clinic', while another said 'they only convey what was detected to be a problem at the clinic'. Men felt it was important to be informed and were willing to be involved in most aspects of maternity care. Many had reservations about being present during the delivery. They also expressed a desire to attend counselling at times convenient to their working hours and most of them suggested Saturdays at the clinics.

Providers' perspectives

Provider attitudes and perceptions before the project started were mixed: 'But this is against our culture'. One provider referred to the cultural practice of the woman going to her mother's home after delivery for a period of about three months, during which time she does not sleep in the same room as her partner: 'What is culture or should I say where is culture when people deliver and go home to a one-roomed house… Of course it won't be everybody... but the young ones…will come, I can assure you…'

Others perceived that male involvement in maternity was something that had been practised by other races: 'I felt that it should not be white and Indian males who accompany their partners to the clinic. Black males should come to the clinic to find out what happens.' Certain staff were concerned that men would not come; some were concerned about responding to difficult issues and questions raised during counselling, while others were not sure what was expected of them: 'I was frustrated of what was going to be and what was going to be expected from us', 'I thought it was additional work from the start'. It was also evident from the discussions that providers themselves were socialised to see maternity as a woman's issue. One man said: 'Even for us, the staff, if a person was accompanied by her partner to the clinic we would make the partner stand outside and let the woman go in alone.' The ages of nurses relative to clients and their perceived attitudes was also raised as a challenge by providers. 'In our clinic we have young and old nurses; the old nurses are not good when counselling young couples; when they talk they take it personal.'

Men expressed interest and willingness to get involved with pregnancy

Providers were also concerned about the following:

- Traditional beliefs (eg a man will lose strength if he sees a woman naked);
- Predominant pattern of relationships (two-thirds of women were not cohabiting with their partners but were in 'visiting' relationships in which the partner would visit them regularly);
- Working men could not attend counselling; and
- Men with multiple partners may not want to be seen with a partner at the clinic.

Some staff perceptions of the project effect were more positive. They said involving men would:

- help fathers have a closer relationship to the child;
- reduce 'promiscuity' as men would be forced to come to the clinic with one partner;
- bring families closer; and
- reduce gender-based violence and rape.

One provider said: 'I feel that one of the reasons the rape cases are so high is that due to males not participating in their daughters' upbringing... the participation of men in maternity would lead to them thinking twice about raping children.'

Although some providers had concerns and mixed reactions at the beginning of the intervention, others were motivated to participate for the following reasons:

- Improved skills in counselling through the training provided;
- An opportunity to see couples 'helping each other' and a 'need to see couples happy';
- Personal experience of not being supported by the partner and the need to ensure that others did not have the same experience; and
- An opportunity 'to speak directly to males'.

Six months after delivery, men and women were followed up to assess if they had been to the clinic for couples counselling and to assess their perceptions on the intervention.

Fig. 1: Reasons given by women as to why couples counselling was helpful

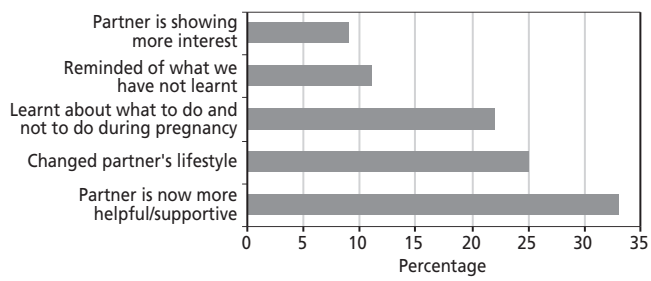
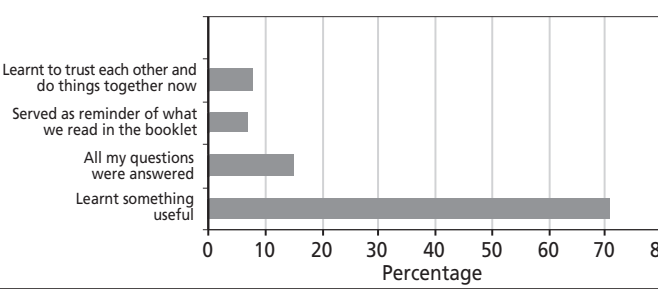


Fig. 2: Reasons given by men as to why couples counselling was helpful



Couples counselling

Clinic registers stated that a total of 524 couples were counselled across all six clinics during the intervention between June 2001 and October 2002 (17 months). Thirty-four percent of those who attended were in the study (table 3). All women attending antenatal care in the intervention clinics were given similar information during their antenatal care health education and couples counselling.

Almost all women who attended couples counselling with their partners said it was helpful and gave the following reasons for this (figure 1).

Table 3: Number of participants who came for counselling

	Intervention women	Intervention men
Aware of couples counselling	90 (n = 726)	71 (n = 556)
Invited partner/by partner for couples counselling	82 (n = 506)	78 (n = 430)
Attended couples counselling with partner	25 (n = 506)	30 (n = 430)
Attended couples counselling alone	20 (n = 506)	10 (n = 430)

More than two-thirds of the men who went for couples counselling said the information gained during counselling helped them in caring for both their partners and their babies (figure 2).

Partner communication

Both men and women were asked about the topics they discussed during the maternity period. For this analysis only matched couples were used (where both partners of a couple were interviewed). Table 4 shows topics discussed by couples post-delivery. Reported levels of discussion were higher in the intervention group. Significantly more intervention couples discussed topics related to STI, sexual relations, immunisation and breastfeeding.

Lessons learnt

During follow-up, few differences were found between the control and intervention groups to support the hypothesised effect of the intervention. Significant positive differences were found, however, in changing communication, partner assistance during pregnancy emergencies, and knowledge of condoms as a method of dual protection.

Although the intervention was intended for all couples in which the woman consented to have her partner participate, not all partners were exposed to the couples counselling intervention. Nevertheless, all participants who were interviewed post-intervention were included in analysis, regardless of actual exposure to the intervention. All women, regardless of their attendance at couples counselling, were exposed to the strengthened clinical service package in the intervention sites.

At least one-third of couples took the opportunity to attend the counselling. This is a positive outcome, given firstly, that this was a very new concept in a community with negligible male participation in maternity care and, secondly, that most couples were not cohabiting. Some men expressed willingness to participate, but were unable due to employment schedules that conflicted with clinic hours of operation. Some were unable to obtain permission from employers, and others were not told of the counselling by their partners. The antenatal booklet was given to most of the women and a high proportion shared the booklet with their partners. The response to the booklet was very positive from all those who read it.

On interviewing providers at the end of the project the following lessons were noted:

Table 4: Issues discussed by matched couples

Topics Discussed	Control couples % (n=528)	Intervention couples % (n=588)
Communication		
STI	64	75*
Sexual relation	75	81*
Family planning	70	77
Whether to have more children	49	54
Immunisation	75	81*
Breastfeeding	83	87*
Baby's health	71	78

* $p < 0.05$

1. There is a need to find comfortable and convenient ways of involving men in reproductive health services

Although both men and women said they are willing to have male involvement in a number of reproductive health services (antenatal care, postpartum visits and family planning consultations), nurses initially felt that not all clients were convinced about this. Having male partners present during the delivery was considered the least popular service. Nevertheless, half of the men and women interviewed said they would like to be involved.

Some were not comfortable about attending with their partners, especially if the women in the group were of different age groups. One provider said: 'I remember the first time we told the women, they laughed because they did not think that men would attend and we asked them if they liked it and they said no. Then we explained to them, and although some still did not like it, there were others that could see that it was going to help them.'

Having male partners present during the delivery was considered the least popular service

Another provider added: 'And another thing, most of our clients are very young and then what I've noticed is that they laugh at each other. If someone has brought their partner, others are giggling, they scrutinise him and so others do not bring their partners. Sometimes the partner is standing outside and I have to go and ask if he accompanied anyone to the clinic and then he'll be comfortable, whereas the sister in antenatal has asked who has brought her partner today and no one answered.'

2. Age difference among clients may pose challenges

'Amongst these grown-up women, you sometimes find that there are very few of them, when they are seated with these kids they feel awkward, so you find that they become shy to bring their partners who are also old. There are very few of them – mostly it is these teenagers who are pregnant.'

3. Open clinic infrastructure can be challenging

Around a fifth of the men reported having sex with another partner in the six months since delivery of the baby, and this raised issues of privacy when attending the clinic with any one of them. One provider was concerned that this may lead to physical fights in the clinic.

Another provider said: 'It is not easy for men to come, though we are trying... and they have got more than one partner so they are afraid to be seen at the clinic with this one. Somebody will see him and then go and tell the other partner that his other partner is pregnant, you see.'

The facilitator asked: 'They know each other?'

The provider responded: 'Yes! And the arrangement of the clinic ensures that everybody sees.'

4. There is a need to involve hospital delivery staff and address infrastructure in labour wards

During the implementation of the project, several male partners accompanied their partners to the labour ward even though the intervention only sought to encourage them to attend counselling sessions at the clinics during the antenatal and postnatal period. However, the providers at the delivery hospitals were not part of the training and subsequently discouraged men from being involved during delivery. This resulted in confusion for clients and clinic staff.

One clinic provider said: 'The couple came back to us and the male partner was fed up. The worst part of it was the way the nurse at the

hospital had spoken to him; she told him that this was not a private hospital. So they came to us but we didn't know what to do.'

One of the reasons stated by hospital delivery staff for turning men away, was that the wards were often crowded and not set up for couples. One said: 'But people are still not allowed because they say that it is not only one woman in the labour ward; sometimes there are two or three.'

5. Despite challenges, providers can be motivated to involve men in reproductive health services

Providers who had been involved in the intervention gave the following reasons for wanting to continue to involve men:

- Appreciation of knowledge and skills;
- Provision of quality care to clients;
- Positive feedback from clients; and
- Staff satisfaction.

Providers had the following to say:

I will still be involved because I can see there are people who are bonding, we are bringing partners together and with this bonding, things are improving because we are seeing fathers bringing their children to the clinic now, and more men are informed about maternal issues.'

'Staff attitudes have changed, client attitudes have changed. We have been given an opportunity to do counselling. Since this project, the quality of service has improved.'

Summary

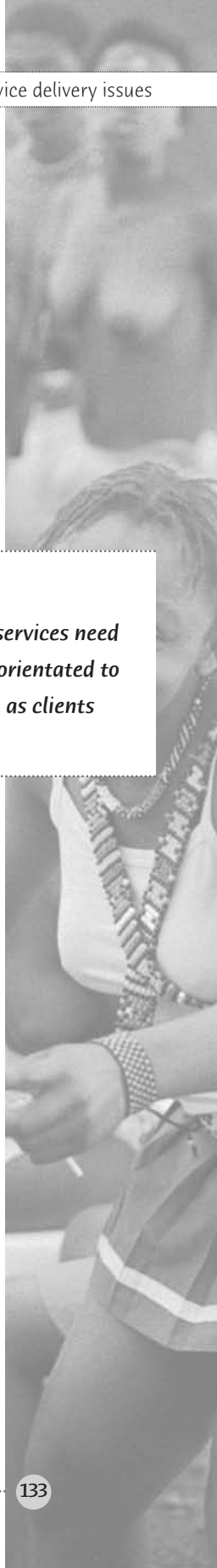
Health services need to be reorientated to see men as clients who are also undergoing practical and emotional changes during pregnancy, and that they need to be prepared for parenting in the same way as women. To improve men's access to services and facilitate the involvement of working men, employer involvement as well as infrastructural issues need to be addressed. Reorientation of services also needs to include hospital delivery centres and sensitisation of clients, perhaps through mass media efforts.

In conclusion, the intervention was feasible, relevant and effective in significantly changing communication patterns, encouraging partner assistance during emergency, and highlighting condoms as a dual protection method. Had the intervention been in place for a longer period and supported by mass communication efforts to encourage men to come to the clinic, we may have seen a much bigger impact.

Health services need to be reorientated to see men as clients

In order for male involvement in the maternity care of their partners to be successful, the following challenges need to be addressed:

- Undertaking wider community education so that more men can be persuaded to participate in their partners' maternity care;
- Addressing infrastructural health service issues and timings of services to facilitate the involvement of working men;
- Training more health providers to serve couples, conduct couples counselling and provide male-friendly reproductive health services;
- Integrating other reproductive health services such as STI, family planning, voluntary counselling and testing, and prevention of mother-to-child transmission with antenatal and postnatal care.



Notes

1. A full report on the results and effectiveness of the intervention is available at www.popcouncil.org/frontiers
2. The results are printed in the final report – see note 1.

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