AJM

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Nurses' and midwives' views on male partner involvement in maternity care in Imo, Nigeria

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Abstract

Background/Aims In 2015, the World Health Organization recommended male partner involvement in maternal and child health as an effective strategy to combat maternal and child health in pregnancy. Healthcare practitioners' acceptance of male partners in maternal and child healthcare is likely to improve provider and patient satisfaction. The main objective of the study was to assess nurses' and midwives' perceptions of male partner involvement in maternity care, and their willingness and constraints to performing it in selected hospitals in Imo, Nigeria.

Methods A mixed-method approach was used to gather data from nurses and midwives in the antenatal care, labour and postnatal care wards of selected hospitals. A semi-structured questionnaire and interview guide were used to collect data assessing the participants' perceptions of male partner involvement in maternity care and of the barriers to it. Quantitative data were analysed through bivariate analysis, using the Chi squared test, and key quotes were extracted from qualitative data to illustrate relevant points.

Results The majority (57%) of the respondent had a good perception of the concept of male partner involvement. The ward that a participant worked in significantly affected their perception (P=0.01). Respondents were willing to accept male partners in maternity care through education and providing more male-friendly services. However, sociocultural, hospital policy and structural factors restricted acceptance of men in the wards.

Conclusions Nurses and midwives in all wards should be educated on the importance of male partner involvement in maternity care. Nurses and midwives need to engage in community health education programmes that will modify cultural constraints to male partner involvement and facilities should modify their structure and policies to be more male-friendly.

Key words: Antenatal; Labour; Male partner involvement; Midwifery; Nurses and midwives; Postnatal

Submitted: 15 June 2020; accepted following double-blind peer review: 27 July 2020

Background

Male partner involvement in maternity care can be defined as the process of change in men's social and behavioural dimensions that results in their playing a critical role in reproductive health care, with the goal of assuring women's and families' wellbeing (Craymah et al, 2017). According to Mersha (2018), male partner involvement in maternity care is an important factor to consider in birth preparedness and complication readiness, because involvement gives men access to vital information about their partner's reproductive health and ensures the man's availability in providing emotional, physical and financial assistance to their partner (Alio et al, 2013). Nurses and midwives play a key role in male partner involvement in maternity care, as they are the first point of contact during the provision of maternity care services and provide information regarding the healthcare needs for women in maternity care. Studies on how nurses and midwives perceive the involvement of male partners in maternity care and their willingness to allow it are limited, but some research has shown that healthcare-related factors that affect male partner involvement in maternity care include the attitude of the healthcare provider, culture, economic challenges, distance to the healthcare facility and infrastructure of the wards (Chris, 2015; Twinomuhangi and

How to cite this article:
Ngwibete A, Ndikom CM, Anyiam FE. Nurses' and midwives' views on male partner involvement in maternity care in Imo, Nigeria. African Journal of Midwifery and Women's Health. 2021. https://doi.org/10.12968/ajmw.2020.0036

Mugyenyi, 2018; Gibore et al, 2019). In some health facilities in Africa, stakeholders have demonstrated a willingness to involve men in maternity care. For example, in Malawi, male partner involvement in antenatal care has been made mandatory by a particular healthcare facility and a study found that women who went to hospital with their husbands were attended to first (Kululanga et al, 2012). Although this measure taken by the stakeholders to ensure male participation was seen by the women that attended the facility's antenatal care as punitive to users of the facility, male attendance and maternal care outcomes improved as a result.

The lack of male partner involvement has been a factor that prevents women from accessing and using maternal health services in many African nations (Mfuh et al, 2016). In Nigeria, men usually hold authority over women, are more educated and are more financially empowered than women and children. This puts many women in the position of needing to depend on their partner (Olayemi et al, 2009; Mfuh et al, 2016). According to Iliyasu et al (2010), there is a need to increase male partner involvement in maternity care through peer-led, culturally sensitive community education and appropriate health system reforms in Nigeria. Based on this, the researchers sought to explore nurses' and midwives' perceptions of male partner involvement in maternity care, as well as their willingness and constraints to performing it in selected facilities in Imo.

Methods

The study was conducted in Owerri, Imo, which is the capital city of the state. Two main tertiary institutions within the state, the Federal Medical Centre and the Imo State Specialist Hospital Owerri were used for this study.

This study used a mixed-method approach, which combined both quantitative and qualitative methods to generate complementary insights that create a bigger picture of the phenomenon under study (Addo and Eboh, 2014). Qualitative research methods were used to understand the perception of the participants and their willingness to involve male partners in care. This gave a comprehensive narrative of the phenomenon being investigated (Addo and Eboh, 2014). The quantitative method analysed numeric data, which helped to bring a deductive understanding of the area under study (Guest and Namey, 2017). A questionnaire was used to gather quantitative data while the qualitative data were collected through semi-structured interviews.

Study population

The study was targeted at registered nurses and midwives who provided midwifery-related care at the antenatal care, labour and postnatal care wards at the two hospitals purposefully selected for the study. These hospitals were selected because they are located in the centre of the city and have high patient numbers; they were considered to have appropriate respondents to address the objectives of interest. The study evaluated nurses' and midwives' perception of male involvement in care and their willingness to accept male partners in the wards.

Since the number of study participants that met the inclusion criteria was small, the entire population was considered for the study and so included all registered nurses and midwives working in the three wards, including the deputy director of nursing services and acting deputy director of nursing services at the selected hospitals. Registered nurses and midwives working in the wards who were on leave, sick or absent during data collection, or who did not consent to provide data for the study were excluded. Overall, 84 people responded and were included in quantitative data collection. For qualitative data collection, nurses and midwives who had 5 years or more experience in active service in the facility were purposely selected. This consideration was made with the assumption that those with many years in service would have a wealth of knowledge on the topic of interest. Overall, this included two heads of unit, three matrons, two ward-based nurses and two ward-based midwives for a total of nine participants.

Data collection

Data were collected using questionnaires and interviews. The researcher visited the wards to collect data from participants via questionnaires, which were given to the head of the

department of each ward who administered them to their subordinates. The researcher was given a date to return to the ward and collect the filled questionnaires; however, the researcher visited the clinics every Tuesday and Thursday to follow up on questionnaire administration. The questionnaire was administered over a period of 2 weeks.

The questionnaire collected data on the sociodemographic characteristics of respondents, their perception of male attendance at maternity care, their willingness to accept male attendance, and their perceived barriers to male attendance at maternity care. Participants' responses on perception were scored out of a total of 7, with responses that indicated a positive perception being given a score of one and responses that indicated a negative perception being given a score of zero. The scores were summed and then categorised, with 4 or higher being categorised as 'good perception' and 3 or lower being 'poor perception'. Participants' responses on barriers and their willingness to accept male involvement were scored using a 5-point Likert scale (strongly agree, agree, undecided, disagree and strongly disagree).

The questionnaire was cross-checked by two research supervisors and other research experts. The questionnaire's reliability was tested using the test–retest technique in which copies of the corrected questionnaire were administered to 10% of the sample size of nurses and midwives at the Madonna University Teaching Hospital. After 2 weeks, other copies of the questionnaire were administered to the same respondents for a post-test. The data was then inputted into the Statistical Package for Social Sciences version 20, where the reliability was calculated using Pearson's moment correlation, with a result of 0.8.

To recruit respondents for interview, the researcher made inquiries with the head nurse for participants who fit the inclusion criteria for interview. With their help, participants were selected. The researcher also visited the head of nursing services, who made recommendations for a midwife tutor to be interviewed alongside the other participants. The researcher visited the selected respondents to book an appointment. Each interview took place at the respondent's office or ward of practice and lasted for a maximum of 30 minutes. The interview was tape recorded, and notes were made by the researcher. The interview was done with nine selected participants (five at the Federal Medical Centre and four at the Imo State Specialist Hospital Owerri) meaning there were multiple sources of information, ensuring that the questions were addressed sufficiently by collecting a range of ideas that increased the validity, quality and reliability of the findings. The data from the interview were transcribed.

Data analysis

Findings from both quantitative and qualitative data were used to elucidate complementary phenomena and diverging points. The interview data were listened to and read by the researcher carefully and repeatedly. Important points were noted and grouped in themes, with major and minor categories. This information was then compared and contrasted.

Quantitative data were analysed using the Statistical Package for Social Sciences version 20. The questionnaires were given numerical codes to facilitate entry and cross-checking. Charts and tables were used to illustrate results. A descriptive statistical approach was used for numerical variables. The Chi-square test was used to test the association between categorical variables. Bivariate logistic regression was also used to assess odds of association between the dependent and the independent variables at a 95% confidence interval and a $P \leq 0.05$ was considered statistically significant.

Ethical considerations

This study complied with ethical and human rights principles. The research was approved by the University of Port Harcourt Ethical Committee (UPH/CEREMAD/REC/MM0R/021). The researcher also acquired ethical clearance from the Ministry of Health (Imostate) and the Federal Medical Centre Owerri to collect data from the facility. Once the research was granted clearance, the researcher moved to the facilities for data collection.

Free, prior and informed consent was respected during data collection, and participants were given the option to opt out of the research at any point. Only those who consented and were willing to freely participate took part in the study.

Results

A total of 84 participants were involved in quantitative data collection and their sociodemographic characteristics are shown in Table 1. The majority were from the Federal Medical Center (54.8%) and were 31–40 years old (53.4%). The mean age was 35.37 years ± 8.54 years. The largest proportion of participants had spent more than 8 years in the service (45.8%), were registered midwives (44.0%) and worked in the labour ward (40.5%). For qualitative data collection (interviews), there were a total of nine participants, one deputy director of nursing, two assistant deputy directors of nursing, a midwife tutor, three matrons and two nursing officers. Two-thirds of these participants had more than 10 years of experience, while the remaining three had between 5 and 10 years of experience.

Perception of male partner involvement in maternity care

After assigning scores to perception questions, the majority (57%) of the nurses and midwives had a good perception of male involvement in maternity care (Figure 1).

Table 1. Sociodemographic data of participants (*n*=84)

Characteristic	Category	Frequency, *n* (%)
Facility	Federal Medical Centre	46 (54.8)
	Imo State Specialist Hospital Owerri	38 (45.2)
Age (years)	21–30	22 (30.1)
	31–40	39 (53.4)
	41–50	17 (23.3)
Mean ± standard deviation	35.37±8.54	
Sex	Male	0 (0)
	Female	84 (100.0)
Length of service (years)	<4	21 (25.3)
	4–7	24 (28.9)
	≥8	38 (45.8)
Education	Registered nurse only	8 (9.5)
	Registered midwife only	37 (44.0)
	Registered nurse and registered midwife	35 (41.7)
	Bachelors	4 (4.8)
	Masters	0 (0)
	Doctorate	0 (0)
Ward	Postnatal care	24 (28.6)
	Labour ward	34 (40.5)
	Antenatal care	26 (31.0)
Rank	Chief nursing officer	13 (15.5)
	Assistant chief nursing officer	13 (15.5)
	Principal nursing officer	23 (27.4)
	Senior nursing officer	11 (13.1)
	Nursing officer 1	10 (11.9)
	Nursing officer 2	14 (16.7)

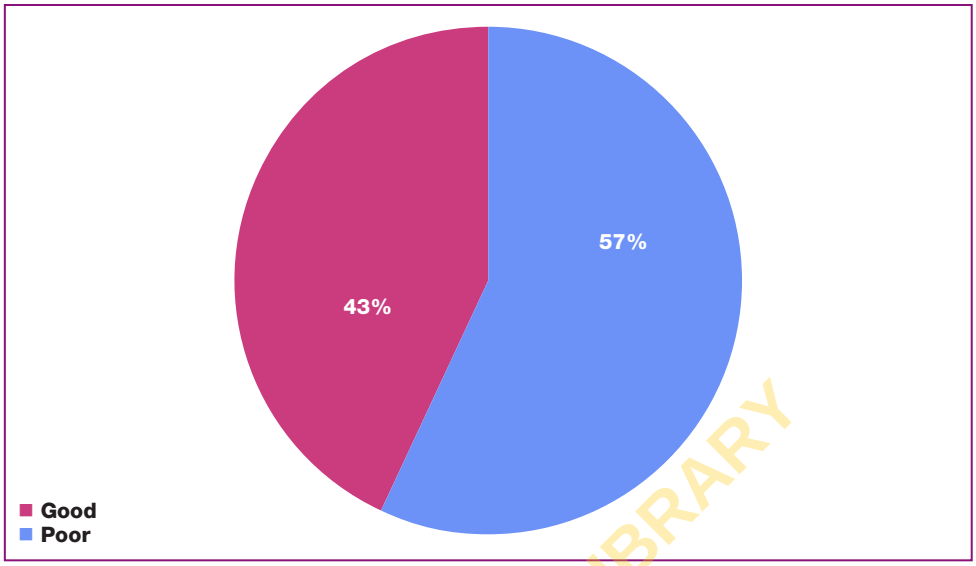

Figure 1. Perception of male partner involvement

The results of the chi squared test for association between sociodemographic characteristics and perception of male involvement in maternity care are shown in Table 2. The majority of the nurses and midwives from the Federal Medical Centre (65.82%) perceived male partner involvement in maternity care positively compared with 34.8% of those at the Imo State Specialist Hospital Owerri. There was a significant difference in the perception of the necessity of male partner involvement between the facilities (P=0.01). Respondents who had more years of experience were more likely to have a positive perception of male involvement. Over half of those who had worked for more than 8 years had a good perception of male partner involvement. However, years of experience did not significantly affect participants' perceptions. A greater proportion of respondents with a bachelor's degree had a good perception of male partner involvement than those who were registered nurses or midwives but there was no significant difference in educational qualification and perception. Respondents in the antenatal care and labour wards were less likely to have a poor perception of male partner involvement in care compared to those from the postnatal care ward (P=0.01).

Qualitative data showed that the respondents generally perceived male partner involvement as an important concept. However, most respondents also perceived male partner involvement as a foreign concept that is widely practised in the western world. Most respondents acknowledged the important role of men as decision makers and providers of care. Participants frequently reported that they thought of men as those who should take financial responsibility during pregnancy, childbirth and childcare and that they should be available for logistics, such as transport and errands. The respondents were very particular about the role of men in complication readiness and birth preparedness, as most acknowledged the importance of men in times when special care was needed because of a pregnancy-related complication.

> **'The men come to visit their children in our ward and most times the only thing they can do is provide for the women and sick child. You know childcare is women duty in our land'.** Participant from postnatal care ward

> **'When we foresee that a complication may arise during the pregnancy, we insist that the woman brings her partner. We also tell the men to provide the needs of the woman before delivery.'** Participant from antenatal care ward

> **'The men in the Igbo society are culturally seen as providers of the family. In case we need anything, we tell them whatever is needed so they can buy for us. We usually**

Table 2. Multivariate analysis of the association of sociodemographic data with perception of male involvement in maternity care

		Perception of involvement in maternity care					
		Poor	Good				
Characteristic	Category	*n* (%)	*n* (%)	df	Chi squared	*P* value	Odds ratio (95% confidence interval)
Facility (bivariate analysis)	Federal Medical Centre	13 (37.1)	30 (65.2)	1	6.29	0.01	
	Imo State Specialist Hospital Owerri	22 (62.9)	16 (34.8)				
Length of service (years)	<4	8 (22.9)	12 (26.7)	2	0.16	0.92	
	4-7	11 (31.4)	13 (28.9)				0.51 (0.07-3.6)
	≥8	16 (45.7)	20 (44.4)				0.45 (0.08-2.60)
Education	Registered nurse only	3 (8.6)	4 (8.7)	3	0.83	0.84	
	Registered midwife only	17 (48.6)	19 (41.3)				1.39 (0.07-28.17)
	Registered nurse and registered midwife	14 (40.0)	20 (43.5)				0.67 (0.05-8.88)
	Bachelors	1 (2.9)	3 (6.5)				0.86 (0.06-11.52)
Ward	Postnatal care	16 (45.7)	7 (15.2)	2	9.28	0.01	
	Labour ward	10 (28.6)	23 (50.0)				0.085 (0.02-0.48)
	Antenatal care	9 (25.7)	16 (34.8)				0.72 (0.17-2.96)
Rank	Chief nursing officer	5 (14.3)	7 (15.2)	5	10.17	0.06	
	Assistant chief nursing officer	10 (28.6)	3 (6.5)				0.20 (0.92-2.11)
	Principal nursing officer	10 (28.6)	13 (28.3)				0.04 (0.00-0.54)
	Senior nursing officer	2 (5.7)	8 (17.4)				0.62 (0.08-4.80)
	Nursing officer 1	2 (5.7)	8 (17.4)				1.05 (0.07-15.73
	Nursing officer 2	6 (17.1)	7 (15.2)				2.56 (0.32-2146

call the men in only when the woman is naughty and uncooperative and they are usually very helpful with such cases.' Participant from labour ward

The participants' responses to questions regarding their willingness to accept male involvement in maternity care are shown in **Table 3**. Approximately one third (33.7%) of the participants agreed that their attitude does not affect acceptance of men on the ward. But a similar proportion (35.7%) were willing to modify health teaching in such a way that matters of interest to male partners in maternity care are included. Almost half (47.0%) were willing to facilitate processes to decrease unnecessary waiting time in the ward, which can improve male partner involvement. Over half (52.4%) of respondents strongly agreed to be more friendly, polite and receptive to men who accompany their spouses in order to improve their involvement in maternity care in the facility. Many agreed that ward infrastructure accommodating only women was sufficient for the provision of their services (41.5%); however, the majority agreed that if management was willing to modify structures (78.3% strongly agree or agree) and policies (76.5% strongly agree or agree) to accommodate male partner involvement, it will help improve male involvement. The largest proportion of respondents agreed that the hospital policy not accommodating men was acceptable, considering ward structure and policy (31.3%), and agreed that their lectures did not need to include elements on male involvement in maternity care (26.4%).

Participants who were interviewed were willing to accept male partners in their wards if some structural or policy modifications could be made. Additionally, cultural factors were reported to affect male partner's participation in midwifery care. Individually, most of the interviewees felt they could only provide health education to improve male partner involvement in maternity care, as hospital policy or cultural factors often prevented men from being actively involved.

> **'We nurses will like men to partake in care of the women and children who are in our ward, but culture and the way our hospital is organised won't allow us. We can only educate the men about how important it is to have them in the wards and care for their wives at home'.** Participant from labour ward

> **'For those who don't know their way around or are in some emergency, we try to facilitate processes for them. You know most men are always in haste so facilitating these processes makes them happy.'** Participant from antenatal care ward

The participants' perceptions of barriers to acceptance of men in the maternity ward are shown in Table 4. The majority of the participants either agreed (31.0%) or strongly agreed (39.3%) that the attitude of some nurses and midwives in the ward discouraged male involvement in maternity care. Two thirds (66.6% total) of the participants agreed or strongly agreed that male partner involvement in the ward was affected by hospital facility

Table 3. Participants' willingness to accept male involvement in maternity care

Item	Strongly agree (%)	Agree (%)	Uncertain (%)	Disagree (%)	Strongly disagree (%)	Median decision
My ward's lectures are good enough and do not need components of male involvement	13 (15.5)	23 (27.4)	10 (11.9)	16 (19.0)	22 (26.2)	Uncertain
I could modify health teaching in such a way that matters of interest to men in maternity care are included	22 (26.2)	30 (35.7)	16 (19.0)	10 (11.9)	6 (7.1)	Agree
I could help facilitate processes to decrease unnecessary waiting time in the ward which can improve male involvement	17 (20.5)	39 (47.0)	12 (14.5)	8 (9.6)	7 (8.4)	Agree
I will be more friendly, polite and receptive to a male who accompanies their spouse in order to improve their involvement in maternity care in my facility	44 (52.4)	25 (29.8)	13 (15.5)	2 (2.4)	0 (0)	Strongly agree
My attitude does not affect the presence of men in the ward	23 (27.7)	28 (33.7)	11 (13.3)	10 (12.0)	11 (13.3)	Agree
If a structural modification to accommodate male involvement is made by management, it might help in making us ready to accept men in our ward	29 (34.9)	36 (43.4)	6 (7.2)	5 (6.0)	7 (8.4)	Agree
If a policy modification to accommodate male involvement is made by management, it might help in making us ready to accept men in our ward	32 (39.5)	30 (37.0)	11 (13.6)	5 (6.2)	3 (3.7)	Agree
Our ward infrastructure accommodating just women is good enough to provide services	16 (19.5)	34 (41.5)	7 (8.5)	15 (18.3)	10 (12.2)	Agree
Our policies do not accommodate males and I think that is ok considering the ward structure and policy	15 (18.1)	26 (31.3)	12 (14.5)	12 (14.5)	19 (21.7)	Uncertain

Table 4. Barriers to acceptance of men in maternity wards

Item	Strongly agree (%)	Agree (%)	Undecided (%)	Disagree (%)	Strongly disagree (%)	Median decision
It is inconvenient for other patients	18 (21.4)	42 (50.0)	12 (14.3)	10 (11.9)	2 (2.4)	Agree
The hospital facility infrastructure does not accommodate men	28 (33.3)	28 (33.3)	8 (9.5)	15 (17.9)	5 (6.0)	Agree
We have limited space in the ward	28 (33.7)	15 (18.1)	8 (9.6)	25 (30.1)	7 (8.4)	Agree
The hospital policy does not allow men onto the ward	30 (36.1)	12 (14.5)	7 (8.4)	23 (27.7)	11 (13.3)	Agree
The attitude of some nurses in the ward discourages male involvement	33 (39.3)	26 (31.0)	7 (8.3)	8 (9.5)	10 (11.9)	Agree

infrastructure. Many (33.7%) strongly agreed that limited space and hospital policy (36.1%) affected male partner involvement in the ward. Half (50.0%) of the participants agreed that the involvement of men on the ward was inconvenient for other patients.

During interviews, participants reported that there were many constraints hindering men's involvement in their partners' care activities on the wards. These factors included cultural factors, the structure of the facility or wards, hospital policy, nurses' attitudes, staff strength, and that the nature of the wards and clinics was not conducive to this practice.

'As you can see our wards are small and even we, the nurses, don't have enough space to work. If they could make the labour ward in such a way that each woman has space for delivery, men can actively participate. We can't let the men come in to see other women naked.' Participant from labour ward

'In the labour ward, the nurses are always under pressure, sometimes the number of patients is way more than the staff. We need more staff to attend to this large crowd. Generally, our nurses and midwives comport themselves so well towards our client. However, you won't blame some of our nurses if they act rudely, it is the pressure in the wards. I also think if we are trained regularly and our staff strength is increased, we can do better especially with male involvement.' Participant from labour ward

'This male involvement is something that is well practiced abroad. Our men here do not understand it. As a staff, we know how important it is for men to be with their women during, labour and in postnatal care, but what can we do when the government has not provided enough space and seats to accommodate our patients. As you can see the antenatal clinic is so tight and when there is no light, it is very unconducive. Men won't want to come and stay here. Even our pregnant women are not comfortable.' Participant from administration

'The crowd at the antenatal clinic is overwhelming and the space is too small. Because of this, the men usually stand or hang around to wait for their wives after the health talks so we can attend to other women.' Participant in antenatal care ward

'We will like both mother and father to come here and take care of the sick children but this is the Igboland and the men are usually preoccupied with making money. The only thing we can do is educate them on the importance of staying with their kids'. Participant from administration

'In some cultures here, men are not allowed to see women give birth so unless these cultural ideas changed, we just can't allow men in against cultural norms. In fact, some men won't even agree to go into the labour ward. It's like a taboo'. Participant from administration

Discussion

Nurses and midwives are essential staff in the provision of maternity care. Male partner involvement has been proven to give better outcomes in case of complications during birthing (Mersha, 2018) and reduces maternal and child mortality if practised. As such, the WHO (2015) has recommended that healthcare providers acknowledge and accept male partner participation during pregnancy, childbirth and postnatal care, in order to improve women's care during this time. Understanding nurses' and midwives' perspective of male partner involvement in maternity care is important to build more male-friendly maternity care services. Generally, the perception of male partner involvement in care among men and women attending maternity care services in Africa is poor (Kululanga et al, 2012; Kaye et al, 2014; Lowe, 2017). However, if nurses, midwives and other health staff have a positive perception of male partner involvement, they are more likely to educate receivers of care on the benefits of this practice. The role of men as decision makers and providers of care in African society cannot be underestimated. Most women rely on men for finances to access healthcare and other services (Kaye et al, 2014; Sharma et al, 2018). According to Kaye et al (2014), men are often responsible for deciding on the kind of care a woman will receive. It is important that nurses and midwives involve male partners in care so they can make better decisions about their partners' care and bring about better health outcomes.

This study revealed that the participants had a good perception of maternity care overall. Qualitative analysis showed that the respondents' ward of practice had a significant effect on the participants' perception of male partner involvement in care (P=0.01), with respondents in the antenatal care and labour wards being less likely to have a poor perception of male partner involvement in care compared to the postnatal care ward. This may be because antenatal care wards in these facilities actively engage their attendees and educate them about pregnancy, birthing and childcare compared to the postnatal care ward, as found by Smeele et al (2018), who also highlighted that people who attended antenatal care could identify at least one sign of a pregnancy-related complication following their visit. As the antenatal care ward involves preparation for labour, it is likely that nurses and midwives involve the partners of attendees for birth preparedness and complication readiness.

The respondents acknowledged the important role of men as decision makers, and providers of care. African communities are often patriarchal, meaning it is common for men to be viewed as responsible for decision making and providing in the family setting. Gize et al (2019) found that the role of a father figure in African often went beyond care provision and also entailed making decisions for those under his care. The respondents were very particular about the role of men in complication readiness and birth preparedness, which has been highlighted as vital by the WHO (2015). Lowe (2017) outlined the importance of men being educated about the danger signs during pregnancy as well as their partners, as they are then more likely to notice these signs early and report them for appropriate attention.

The respondents were willing to accept male partners in maternity care overall. Most participants agreed to make ward teachings and care actions male-friendly and show positive attitudes to male partners who visit the facility, such as assisting men by facilitating processes, according to one respondent. If ward teaching and practices are made more male-friendly, men will be more likely to understand how to support and care for their wives while they are at the maternity units and will willingly provide support for their

partners. There are examples of successful integration of male partner involvement in maternity care in the literature. This integration can involve participating in childbirth education classes together, discussing birth preferences in advance, timing contractions, looking after himself and other children, providing distractions from pain during birth, documenting the experience, and praising and encouraging the labouring woman (WHO, 2011; Redshaw and Henderson, 2013; NHS, 2019). Ward teaching can educate men on ways of providing support to their partners. According to Vermeulen et al (2016), when healthcare professionals show a positive attitude (being receptive, polite and respectful) to men who attend healthcare services with their partners, there is a tendency for them to return for subsequent visits. Studies have shown that healthcare providers' attitudes, long waiting times and complicated processes that patients go through when assessing care can deter men from participating in care (Chris, 2015; Maluka and Peneza, 2018; Sharma et al, 2018). If nurses and midwives are to make services at maternity units male friendly, there is a need to modify their attitudes, processes and ways in which they offer care to women who visit the clinics with their partners.

According to the respondents, cultural factors, the structure of the facility or ward, hospital policy, nurses' attitude, staff strength, and the nature of the wards and clinics are among the main factors that hinder acceptance of male partners at the health facilities. Many studies have affirmed that sociocultural factors, hospital policy and healthcare workers' attitudes are major factors that prevent men from attending maternity care services (UNFPA, 2016; Mersha, 2018; Sharma et al, 2018; Gibore et al, 2019). In Africa, cultural beliefs restrict men from participating in some maternity services. For example, in most African nations, men are not allowed to see birthing women (UNFPA, 2016). According to Lowe (2017), most men believe attending maternal and child health services is not important. Chris (2015) highlighted that even when men are forced to attend antenatal care services with their partners, the unconducive environment and long waiting time discourage them from returning. Therefore, it is necessary for healthcare workers and stakeholders to engage in rigorous community health education programmes that will modify these cultural beliefs that restrict men from attending maternity services. The authors also recommend that hospital structures and policies are altered to become more male-friendly. Putting television sets in waiting rooms, reducing waiting times and making labour and birthing rooms private are all ways in which male involvement can be encouraged (Redshaw and Henderson, 2013; Chris, 2015; Gibore et al, 2019). It is also necessary for facilities to increase nursing staff strength, to reduce the workload burden on nurses within maternity wards. This will give nurses and midwives more time to attend to partners who come for care with their spouses.

Conclusions

The study used a combination of quantitative and qualitative approaches to collect data from nurses and midwives working in maternity wards. This study highlights that overall, the majority of participants had a positive perception of and were willing to accept male partners in maternity care. However, sociocultural factors, hospital policy, hospital and ward structure and staff strength were reported to hinder acceptance of male partners in the maternity ward.

Recommendations

For male involvement in maternity care to be successfully implemented by nurses and midwives, the authors recommend the following. Health facilities in conjunction with the health ministry should create seminars and workshops on the importance of male partner involvement in the maternity ward to help nurses and other healthcare providers appreciate the important role of the male partner in maternity and childcare. Nurses and midwives need to modify ward teachings and practices at antenatal care, labour and postnatal care wards in such a way that male partners will be actively involved at sessions and participate in care. There is an essential need to modify facility infrastructure in such a way to accommodate male partners (male-friendly facilities). Nurses and midwives should more actively encourage male partner involvement by educating visitors in the various wards about the importance of male partner participation in maternity care. The adoption of a

couple-approach to providing care in maternity wards will be important. A couple-approach where couples are attended to and counselled together from prenatal clinics to maternity clinics will lead to a better appreciation of the participation of men in the care of their spouses. Lectures in the antenatal care wards should be modified to include content about male partner involvement and its advantages.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

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