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Male Partner's Role during Pregnancy, Labour and Delivery: Expectations of Pregnant women in Nigeria

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Abstract

Objectives: To evaluate the expectations of pregnant women on the role of the male partner during conception and delivery.

Methodology: A prospective multi-centre observational study comprising 506 pregnant women at eight health facilities in Ilorin, Nigeria from January to June 2014. Consenting women were recruited at antenatal clinics using multistage purposive sampling and a self-administered questionnaire was administered with provision for interpreters in local dialects for those without western education. The data was analyzed using SPSS using percentages and chi-square test; $p < 0.05$ was termed significant.

Results: Participants were aged 17 to 49 years (mean 30.23±4.81), 82.4% desire male partners company during antenatal clinic visits and 59.1% experienced this in index pregnancy. During labour and delivery, 427(84.4%) want company; 345(80.8%) chose the male partner with 211(57.7%) hoping men will appreciate the value of females afterwards although 27.9% feared the men may disturb the health workers, 72(14.2%) male partners attended previous delivery and 84.8% of the women were satisfied with the experience. Significant predictors of support for male partner's presence at delivery were maternal age ($p=0.001$), secondary or higher education ($p=0.001$) and parity less than four ($p=0.001$); religion ($x^2$1.010; $p>0.001$) and social status ($p>0.001$) were statistically insignificant. Pregnant women wanted education for male partners on care of pregnant women (77.0%) and sex during conception (25.2%).

Conclusion: Parturient desire male partners' presence at deliveries but their past participation was low; health facility modifications and education for men are required to meet the desires.

Keywords: Male partner, Parturient, Company in labour, Pregnancy, labour and delivery

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Introduction

Globally, there has been an increasing trend in the need for involvement of men in health care delivery due to their multiple roles as partners, husbands, fathers or siblings. Despite the communal and health system demand from male partners, pregnant women have desires expected from the men during conception, labour and delivery. Men in developed countries have to a large extent fitted into this role unlike those in developing countries where male participation has been reported as weak. [1] It was reported that many men in low resource countries do not accompany their partners to the health facility during pregnancy unless there is a complication. [2] Others wait outside at the clinic while the woman participate in health talk and consultation by the health worker. [3] Therefore, the men are unaware of the health promotion and disease prevention strategies discussed at these sessions. Men often control the family finance; thus, they may disregard health promotion until complications arise partly due to ignorance. This may be an important hindrance to improvement in maternal, newborn and infant health in low resource countries. At other times, health workers disregard the men because they consider only women as beneficiaries of maternal health programmes. [3] This is a misconception with the potential to further alienate men from participation in reproductive health programs.

In patriarchal societies to which most low resource countries belong, men often take unilateral decisions that bothers on women's health while viewing pregnancy, labour and delivery as women's affair. [4] However, men can provide emotional support, empathy, participate in preparation for the baby's arrival and provide company during antenatal hospital visits, consultation and delivery. [5]

Companionship in labour and delivery provides emotional benefits to the couple [1] as well as health-related benefits including better labour outcomes, earlier initiation of breastfeeding and increased birth intervals. [6] This study aimed at evaluating the expectations of pregnant women from their male partners during pregnancy, labour and delivery among antenatal clinic attendees.

Materials and Methods

The study was a cross-sectional multicenter survey in Ilorin, Nigeria which is a transition between the Southern and Northern part of the country with a mix of the cultural, religious and socioeconomic characteristics of the regions. Eight study sites were selected based on multi-staged sampling to include equal number of public and private facilities. The list of all health facilities in the city was obtained (n=152), and eight facilities selected at random by balloting from two boxes containing the names of all facilities. These were four public and four private health facilities. The choice of these multiple heath facilities was to have a wider representation of women from the various socioeconomic groups.

Eligible participants were consenting pregnant women receiving antenatal care at the study sites while those who did not consent to participate in the study or those not receiving antenatal care at the study sites were excluded.

The sample size was calculated using the formula [7]

$$n = 2\frac{z^2 pq}{d^2}$$

n= desired sample size
z= standard normal deviate usually set as 1.96 which corresponds to 95% confidence interval
p = proportion in the target population estimated to have a particular characteristic i.e. 0.93 (i.e. 93%) [1]
q = 1.0-0.93 = 0.07
d= degree of accuracy desired usually set at 0.05

$$n = 2\times\frac{1.96^2 \times 0.93 \times 0.07}{(0.05)^2} = 2\times\frac{3.84 \times 0.93 \times 0.07}{0.0025}$$

$$n = 200 \text{ participants.}$$

With attrition of 10%, the minimum number of participants was 220.

Recruitment for the study was at the antenatal clinic; there was information about the study during the health talk and mother craft classes followed by informed consent from eligible pregnant women. The instrument for the study was a self or interviewer administered questionnaire depending on the

level of education of the women. Translators skilled in translation and back translation were interviewers for women who could not communicate with English language. Each consecutive, consenting, eligible woman was recruited into the study and the social class was determined for each woman.[8] The male partner was an individual of male gender with whom the pregnant woman was in intimate sexual relationship and was responsible for her pregnancy whether they were legally married or not. Formal education refers to individuals who were educated in English teaching schools at primary, secondary or tertiary level. Statistical analysis was done with SPSS version 20.0, the Pearson's chi square was used for comparison with calculation of odds ratio at 95% confidence interval. Logistic regression was done using Wald test and B coefficients, p value <0.05 was termed significant. The study complied with recommendations for Human research and Institutional ethical approval was obtained from the ethical review committee of the University of Ilorin Teaching Hospital (UITH), Ilorin before the commencement of the study.

Results

There were 506 participants in the study with a mean age of 30.23±4.8 years (range 17 to 49), 180 (35.6%) were primipara, 211(41.7%) belonged to high social class while 317(62.6%) had tertiary level of education (table 1).

In table 2, 417(82.4%) women want male partner to accompany them to antenatal clinic and 299(59.1%) have experienced this at least once during current pregnancy. Among the 422 (83.4%) of participants who have had ultrasound scan in index pregnancy, 172(40.8%) were accompanied by the partner. In all, 409(80.8%) women want male partners of pregnant women to be educated about pregnancy especially concerning how to take care of pregnant women (315[77.0%]) and sex during pregnancy (103[25.2%]).

Table 3 showed that 427(84.4%) women desire companionship during labour and delivery with 345(80.8%) preferring the male partner. The commonest reason for preferring the male were for the men to appreciate the value of women (211[57.7%]). Majority of women who wanted the partner excluded opined that men do not play any role in labour and delivery (55[39.3%]). Seventy two (14.2%) of the men were present at previous deliveries of the partners and 84.4% of the women were satisfied with the men's presence. The commonest reason for partner's absence at previous delivery was refusal by the health provider (141[32.5%]).

In table 4, the significant predictors of the attitude of pregnant women to the presence of male partner at delivery included age of 20 years and greater (p=0.001), women's level of formal education (p=0.001), rising parity from para 0 to para 4 (p=0.001), male partner presence and support at previous delivery (p=0.001) and partner accompanying woman for ultrasound scan in index pregnancy (OR1.65, 95%CI1.03-2.67; p>0.001).

In order to meet their expectations, 138(27.3%) women want male partner education during antenatal period while 301(59.5%) women want single patient labour/delivery rooms to be provided by the health facilities.

Table 1. Socio-demography of participating pregnant women

Parameter	Frequency (n = 506)	Percentage (%)
Age		
Range (Min – Max)	17 – 49	
Mean ± SD	30.23 ± 4.81	
Level of formal education		
None	5	1.0
Primary	39	7.7
Secondary	145	28.7
Tertiary	317	62.6

Religion		
Islam	288	56.9
Christianity	216	42.7
Others	2	0.4
Social class		
High	211	41.7
Low	295	58.3
Parity		
0	96	19.0
1	180	35.6
2 – 4	226	44.7
≥ 5	4	0.8
Mean ± SD	1.41 ± 1.0	

Table 2. Pregnant women's expectations from the male partners during pregnancy

Parameter	Frequency	Percentage (%)
Should men follow the partner to antenatal clinic?		
Yes	417	82.4
No	89	17.6
How frequently should a man follow his wife to antenatal clinic?		
None, not necessary	89	17.6
Once	32	6.3
As many times as possible	293	57.9
All the time	92	18.2
Has your partner followed you to antenatal clinic in this pregnancy?		
Yes	299	59.1
No	207	40.9
Why did he not follow you? (n=207)		
He works in another town	86	41.5
I will feel ashamed if he follows me	5	2.4
I can take care of myself	55	26.6
He should rather go and get money	19	9.2
It is not the custom	9	4.3
Others	33	15.9
Have you done an ultrasound scan in this pregnancy?		
Yes	422	83.4
No	84	16.6
Did your partner follow you? (n=422)		
Yes	172	40.8
No	250	59.2
Is it necessary to educate men whose partners are pregnant?		
Yes	409	80.8
No	97	19.2
***What should they be taught? (n = 409)**		
Effect of pregnancy on the woman	120	29.3
How to take care of a pregnant woman	315	77.0
How to be patient with their partners	115	28.1
Sex during pregnancy	103	25.2

*Multiple responses were allowed

Table 3. Pregnant women's expectations from the male partners during labour and delivery

Parameter	Frequency	Percentage (%)
Would you like someone to be with you in labour and delivery?		
Yes	427	84.4
No	79	15.6
Who will you like to be with you? (n = 427)		
Husband	345	80.8
Mother	46	10.8
Mother-in-law	12	2.8
Sister	20	4.7
A friend	4	0.9
Why should men accompany their partners during delivery (n = 366)*		
To know how painful it is	118	32.2
To treat women better	88	24.0
To like the child better	29	7.9
Will encourage women in labour	77	21.0
To appreciate the value of women	211	57.7
May make men to allow family planning	31	8.5
It may stop extra marital affairs	19	5.2
Why should men stay away during delivery? (n = 140)*		
Delivery is sacred for women only	23	16.2
Men may cry during the delivery	26	18.6
Men do not have any role to play	55	39.3
Men may collapse and faint on seeing blood	4	2.9
Men may not like their wives after delivery	3	2.1
I will feel ashamed	7	5.0
It will make me not to push well	12	8.6
May disturb the health personnel	39	27.9
What influenced your opinion?		
Culture	108	21.3
Religion	108	21.3
Personal opinion	290	57.6
Why was he absence at previous delivery? (n=434)		
He was not in town	114	26.3
I did not know that he can be there	99	22.8
I did not want it	80	18.4
The health care provider refused	141	32.5
What was the outcome of your partner's presence at delivery? (n=72)		
I felt less pain	12	16.7
He supported me	49	68.1
He increased my anxiety	11	15.2

* Multiple answers were allowed

Table 4. Predictors of the pregnant women's preference about presence of male partner at labour and delivery

Parameter	Should men be allowed Yes n (%)	No n (%)	χ^2 (*p* value)	OR (95% CI)
Age group				
≤ 19	0 (0.0)	1 (0.7)	0.000 (1.000)	
20 – 29	166(45.4)	66(47.1)	43.103 (<0.001)	
30 – 39	184(50.3)	70(50.0)	51.165 (<0.001)	
40 – 49	16(4.4)	3(2.1)	8.895 (0.003)	
Religion				
Islam	203(55.5)	85(60.7)		
Christianity	161(44.0)	55(39.3)	1.010 (0.315)	0.82 (0.54 – 1.24)
Social class				
High	156(42.6)	55(39.3)		
Low	210(57.4)	85(60.7)	0.460 (0.495)	1.15 (0.76 – 1.74)
Level of Education				
None	3(0.8)	2(1.4)	0.000 (1.000)	
Primary	24(6.6)	15(10.7)	2.077 (0.150)	
Secondary	100(27.3)	45(32.1)	20.862 (<0.001)	
Tertiary	239(65.3)	78(55.7)	81.77 (<0.001)	
Parity				
0	74(20.2)	22(15.7)	28.167(0.001)	
1	130(35.5)	50(35.7)	35.556(0.001)	
2-4	159(43.4)	67(47.9)	37.451(0.001)	
≥5	3(0.8)	1(0.7)	0.250(0.617)	
Choice of companion				
Husband	313(85.5)	32(22.9)	28.167(0.001)	
Mother	22(6.0)	24(17.1)	0.087(0.768)	
Mother-in-law	6(1.6)	6(4.3)	0.000(1.000)	
Sister	7(1.9)	13(9.3)	1.800(0.179)	
Friend	0(0.0)	4(2.9)	2.250(0.134)	
Accompanied by partner for USS*				
Yes	135(44.0)	37(32.2)		
No	172(56.0)	78(67.8)	4.280(0.028)	1.65(1.03-2.67)
Effect of partner presence at delivery				
I felt less pain	8(15.1)	4(21.1)	1.333((0.248)	
He supported me	37(69.8)	12(63.2)	12.755(0.001)	
He increased my anxiety	8(15.1)	3(15.8)	2.273(0.131)	

USS: ultrasound scan

Discussion

This study showed that pregnant women desired male partner involvement during pregnancy, labour and delivery. However, the partners have not been able to effectively meet these needs with family, social, individual and health service factors playing a role in the dynamics towards the realization.

In the antenatal period, parturient want their partners to accompany them to the antenatal clinic as many times a possible as well as to ultrasound examination. The percentage of men who accompanied their partners to antenatal clinic was higher than 18.7% from Northern [4] and 24.0% from South West, [9] Nigeria although men's presence at previous delivery in this study was lower compared to 27.1% [9] and 63.9% [10] in South West, Nigeria. This may suggest that accompanying the woman to antenatal clinic is easier to comply with than presence at delivery by the male partners.

Majority (80.8%) of participants want their partners to be educated during antenatal period. The priority topics for discussion suggested by the participants in this study bothered around the effect of pregnancy on the woman, sexual activities and the need for male partner support during pregnancy. These were similar to the report of a previous study among parturient.[11] The physiological effect of pregnancy often takes its toll on the woman's ability to perform household chores with reduction in sexual desire especially in the first and third trimesters. [12] Often, the man appears too demanding and the woman rejecting; this requires understanding by the couple. Instead of penetrative sex, women often prefer close physical contact with a desire to be held [13] while a change in position is preferred in advanced pregnancy. [14] Inability to properly handle the situation contributes to making pregnancy a heightened period for domestic violence and male partners have been reported to be the commonest perpetrators. [15]

This study found that many participants were in commuter marriages and the male partners work in other cities making them unavailable. Commuter marriages are characterized by one spouse being resident in the family home, often with work and child-care responsibilities, while the other spouse works and lives away from home for extended periods. This arrangement of family life is growing in number and poses unique challenges to families and family relationships. [16]

The awareness among parturient that men could be at childbirth was high and similar to 75.5% from another report from Nigeria. [10] This portrays a good level of information dissemination about the role of the male partner. However, both studies were conducted in state capitals where majority of educated citizens reside with better social infrastructures. Therefore, the situation in the rural areas may be different although studies from such areas are not available.

The result of this study showed an improvement from a previous study conducted in Nigeria where 28.9% women accepted male partner as companion in labour and delivery. [17] The reasons for non-preference of the partner included personal embarrassment and lack of privacy [17] by the woman similar to this study.

The concern of some women that the male partner may disturb the health provider as expressed in this study has been linked to their non-preparedness for the role. Usually, the men do not know what to expect or do during labour and delivery. Therefore, it has been advocated that the male partners should be educated in the antenatal period and assigned specific roles which they can perform during delivery. [11] This will make them feel welcomed and their presence participatory as well as promote personal satisfaction. Companionship in labour and delivery has been reported to improve contraception uptake and birth spacing. [6, 11]

Women who viewed the partner's presence during previous delivery as supportive remained favorably disposed to it postnatal; this signifies a measure of satisfaction similar to 66.7% women desiring partner's presence in subsequent delivery in another study. [17]

The leading cause of the absence of the male partner at the last delivery was refusal of the health care provider. This has been a concern from a previous study [2] signifying a need for reorientation of health care providers to the advantages of the male partner's company and the ethics of granting such request when made. However, many facilities

in Nigeria and many low resource countries have general labour and delivery rooms making it impossible for men to be present. This validated the leading suggestion by participants for individualized labour and delivery rooms similar to reports of other studies. [1, 11]

The significant influence of age, parity and rising level of formal education in predicting positive attitude to the preference of male partner at delivery corroborated previous reports. [10, 11] This may be due to the better access to information as education increases. However, the positive preference did not affect grandmultipara and those at extremes of age in this study (teenager and above 39 years) although there were fewer women in these groups. The statistical non-significance of the social class suggests that the desire cut across social classes irrespective of economic empowerment contrary to expectation that women of low social class may not be favorably disposed to it. Majority of women wanted their partners to attend births so as to receive better treatment afterwards. This view was expressed by women in a South African study who wanted the men to see how women suffer in the delivery room so as to treat them as ladies afterwards. [3]

The reports on the influence of religion especially Islam on the preference of parturient for male presence at delivery has varied. It was not a significant predictor in this study; many women in Republic of Iran had a positive attitude towards presence of male partner at delivery [11] while it was a major hindrance among Muslims in northern Nigeria. [4]

Another influence is the perception of women about the attitude of health care providers. Some women believe the partner's presence will make the health providers to treat them with respect. [3] There was a report of dissatisfaction by women relative to care received at health facilities in low and medium income countries during labour and delivery. These include verbal abuse from the health providers, their poor attitude, lack of compassion and tendency to be easily angered. [18] This calls for an improvement in maternity care service delivery in low and medium income countries.

However, the desire for presence of male partner at delivery is not universal with some women mainly from low resource countries refusing it. [4, 17, 19] This represents an interplay of sociocultural, [1, 19] religion, [4] and personal reasons [17] among the women. In reports from Zambia and South Africa, [3, 19] some women want the partners to participate in antenatal clinic visits, accompany them to hospital during delivery but stay out of the delivery room. In some cultures, the man is viewed mainly as the provider while pregnancy support is regarded as a female role. [2, 19]

The strength of this study includes its multi-center nature and inclusion of women across varied social, religious and educational levels. The limitations include the restriction to one geographical area and its conduct in a major city. These may limit its application to women in different environments. Therefore, studies in areas with different geographical, social, education, religion and cultural orientations are required to allow comparison.

This study concludes that there is a need to address the influence of culture, ignorance, religion, commuter marriages and health facility limitations to encourage men to effectively meet the expectations of their partners during pregnancy, labour and delivery.

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