Experiences, views and needs of first-time fathers in pregnancy related care: a qualitative study in south-east Nigeria.

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Abstract

Background Given the importance of paternal involvement in maternal care, there is need to prepare first-time fathers to actively participate in pregnancy and childbirth in Nigeria. This study explores the experiences and needs of first-time fathers and the influence of these on their involvement during pregnancy and childbirth in Nigeria.

Methods Semi structured interviews were conducted with 50 men recruited from workplaces, health centers, and markets in rural and urban settings in south-east Nigeria. Using an interview guide, questions were asked to explore the needs of first-time fathers and understand how their needs influenced their involvement during pregnancy and childbirth. Data was transcribed and analysed using thematic content analysis.

Results Six major themes were identified pertaining to the experiences and needs of male partners experiencing pregnancy and childbirth for the first time. Inexperience, cultural beliefs and perception of gender norms influenced the most the support male partners were able to give to their spouses and the support received from their social support networks. Two main needs were identified: the need to be informed and the need to know about the cost of care in health settings. The male partners revealed how the information obtained during this crucial time impacted their choices and decisions.

Conclusion Male partners experiences revealed the influence of gender norms, beliefs, and social support on male partner involvement in pregnancy and childbirth. First time fathers need more information and attention and this study presents insights into what local health settings can do to ensure their informational needs are met. **Keywords:** male involvement, first-time fathers, pregnancy, Nigeria

Background

High maternal mortality remains a reoccurring issue of public health concern in developing countries. Engaging fathers in pregnancy related care is highly crucial now because they can play a central role that can greatly improve final birth outcomes.(1–3) A growing body of literature promoting the involvement of male partners in every aspect of maternal care have reported improvements in the utilization of health services during pregnancy, optimal antenatal care attendance, birth preparedness and improved maternal health outcomes. (4–13). Male partners have an important role in providing support for their spouses which creates an all-round sense of security necessary for a successful pregnancy and childbirth experience(14). Their participation and engagement has been associated with lowered maternal stress levels, lowered occurrences of antenatal and postpartum depression, increased utilization of maternal health services, readiness for birth complications and positive birth outcomes. (9,11,13,15,16). Male partners are natural providers, who can ensure that the appropriate nutritional and health needs of their spouses are met during pregnancy.(6). In addition, with the approaching expected due date, they are also able to provide valuable support especially in ensuring that important gaps such as those related to finances and transportation are covered (17).

Transitioning into fatherhood is a significant experience for many first-time fathers. (17). In addition to the joyous anticipation of a new baby, most fathers are susceptible to stress and emotions such as worry, helplessness and fear during this phase (17–24). Several studies have shown that fathers experience elevated levels of stress and other emotional difficulties as they transition into fatherhood (24–26). Even though discussions surrounding emotions among men are unpopular, they are strong enough to hinder male involvement in pregnancy related care, and therefore should be researched on especially in patriarchal settings(26).

The perceptions of male partner involvement during pregnancy differs in societies. In many traditional settings like Nigeria, the standpoint of the society, health facilities inclusive regarding all pregnancy and childbirth matters leans heavily on the mother of the unborn child(27,28). Because women are placed in the forefront of these issues, the involvement of men is not considered a priority.(27,29). Maluka and Peneza studied the perceptions of male involvement in pregnancy in Malawi and revealed that the perception of the traditional roles of men in pregnancy strongly hindered their participation in pregnancy and delivery. The study reveals that the men had no desire to be more actively involved in antenatal care and delivery beyond their roles as providers(30). Alternatively, other studies now show a growing willingness in men to be involved in pregnancy and related reproductive health matters(31–33).

Since the twentieth century, societies are experiencing remarkable social and cultural modifications regarding the roles of fathers and mothers in the family(34). In the literature, a strong engagement and support from fathers in western societies has been reported (35–37). For instance, Pleck et al describes in their study the evolution of fatherhood in America: from the colonial father, to the distant bread winner, to the modern involved dad, to the father as co-parent(38). Hence, well informed fathers are increasingly more aware of their roles and are better involved in the process from pregnancy to childbirth(39–41). Within the Saharan African context, some researchers have explored male partner involvement in maternal care. However, understanding the needs of male partners at this crucial time remains an understudied area.

This study focused on understanding the needs, experiences and opinions of male partners facing pregnancy and childbirth for the first time. By exploring male partners experiences, views and needs in the African context, the main goal is to understand the impact of these on their actual involvement in pregnancy and delivery. Gaining this knowledge will also help health professionals understand the support male partners need so as to improve overall pregnancy and birth experiences (42).

Theoretical framework

In designing this study, the social support theory provided a foundation on which our understanding of father's involvement in pregnancy could be explained. Social support is described as the help provided through social relationships and interactions(43). Earlier studies have shown how social support networks, comprising of spouses, friends and family members, can be beneficial to people's health and

wellbeing in several contexts, especially among people going through stressful life events(44,45). Four main types of social support have been described by Bartholomew Eldredge et al. These are: emotional support (provision of empathy, love, trust and caring), instrumental support (provision of tangible aid and services), informational support (provision of advice, suggestions and information) and appraisal (provision of feedback useful for self-re-evaluation and affirmation). (46) In this study context, two aspects of social support were very crucial. First, support provided through the relationship experience between male partners and their spouses, evident when they provide the needed help in pregnancy. Secondly, male partners interactions within their social network as they transitioned into parenthood. This is particularly important because male partners in these settings are brought up to be in control and to take decisions for the family. How this relationship with their spouses and their social support network are influenced by these internalizations of the male gender roles is crucial to understanding their involvement and to explore their ability to adjust due to need.

Methods

Design

The design of this study utilized a descriptive qualitative approach. Data was collected using semi structured interviews which allowed a deep exploration into the perceptions and experiences of male partners in pregnancy and childbirth. Of interest to us in this study was the exploration of the under-researched area of the needs of male partners in rural and urban settings in Nigeria.

Settings

This study was performed in Umuahia, the capital of Abia State and in two surrounding rural communities (Amaba and Amuzukwu) all in Abia State Nigeria. Abia State is one of 36 States in Nigeria and one of the five states that make up the South-eastern region. The interviews were held in locations the participants were comfortable with.

Urban

Four health facilities were sampled in the urban settings: the government owned Federal Medical Centre and three privately owned hospitals; two belonging to two private general practitioners and the other belonging to the Catholic church in Umuahia. The federal government owned hospital was purposively selected because it is the biggest hospital in the city and attracts health seekers from Abia state and the surrounding states in the south east geopolitical zone. In addition, it is a major referral hospital for private owned hospitals and health care centres in the surrounding rural communities. To capture the views of other participants from private health facilities, the three private hospitals were purposively selected based on their popularity by male partners recruited from work settings. All three hospitals were in three

different local government areas in Umuahia. In addition to the hospitals, four public and private organisations and one local bar were included in the sample in the urban settings.

Rural

The health centres in Amaba and Amuzukwu villages was the main setting for our studies in the rural communities. Each village had one health centre containing two (Amaba) or three (Amuzukwu) experienced nurses and four trained auxiliary workers to care for the inhabitants of these communities who are predominately subsistent farmers, local businessmen or traders in the local market. Amaba and Amuzukwu communities had 5,112 and 16,374 inhabitants respectively, of which 1,125 and 3,602 were women of childbearing age. Additionally, the village market square in each the villages and a local church in Amaba village were purposefully chosen to find people who linked the researcher to other male partners, traditional birth attendants and the local pharmacist.

Participants and recruitment

Male partners were recruited from hospitals, health centres, public and private working places and from open market squares. Fifty male partners, varying from 23–38 years of age participated in this study. 26 from the urban city and 24 from the rural communities. All 26 men in the urban were at least married traditionally. Only 7 in the rural communities were unmarried. 30 male partners both from the urban and rural communities described themselves as civil servants, 10 were entrepreneurs, others were local farmers($n = 5$), local fashion designers ($n = 2$) and handymen($n = 3$). 26 participants had a university education, of which 22 resided in the urban. 17 participants had completed their O levels. Only 7 participants in the rural communities, described themselves as non-educated.

The researchers acknowledge the role of a gatekeeper, who played a huge role in facilitating access to potential participants and organizations for research. The initial plan of the study was to recruit all participants in the urban region from federal hospital because of its popularity in the region. Interestingly, male partners were rarely found in the maternity units in this hospital. The facility was full of pregnant women and the health care professionals who attended to them. The few partners interviewed, were recruited with the assistance of their wives, who let the researcher interview the few willing husbands as they dropped them at the hospital for their routine antenatal check-ups. Lateness to work was the major reason given by most male partners who refused to participate. In the absence of male partners to recruit in this hospital, the researcher sampled three private hospital settings to recruit more male partners for the study.

The researcher included work settings, to recruit male partners where the society expected them to be. For men approached at their workplaces, interviews took place at a convenient time in their offices with the permission of their various organisations. For the few interviews at the rural market squares, it was the most difficult to find a quiet place to conduct interviews because participants lived far into the villages

and were only available at night in their homes. Most interviews occurred in a corner with the least noise and human interruptions.

Only participants over the age of 18 years, recent father or with a wife pregnant with first child was interviewed for the male partners.

Data collection:

Interview guide was inspired by studies carried out in related African settings(2,47). To introduce discussions with the male partners the following questions were asked: (1) What are the expected roles of male partners during pregnancy? (2a) Tell me more about your experiences during the pregnancy? (2b) and childbirth? Based on their responses, more questions were asked about their needs, support received, and questions they might have had during the transition period regarding pregnancy and childbirth (3) Should men go with their wives for antenatal care visits (3b) why? (4) Do you feel comfortable to attend ANC with your partner? (5) What do you think is the husband's role during delivery? (6a) What are your thoughts about how men can better cope with pregnancy? (6b) And delivery? (7) Please share your experiences in hospital settings during this period. In addition, we asked how they were able to decide on the birthplace. For male partners, whose spouses were still pregnant, we wanted to know if the birthing decisions were already made, the circumstances surrounding the decisions and what informed their final decisions. (8) Did you experience any anxieties during the whole process?

All interviews were audio recorded with permission and field notes taken for other important discussions with participants that could not be recorded.

Data analysis

The field records and notes were expanded into transcripts. Transcripts were read and analysed as guided by the thematic analytical technique of Braun and Clarke (48). This technique provided a clear approach in analysing our data to enable us identify patterns, organise themes, compare and validate our findings in line with our research questions. The data from the male partners, priests and the health personnel were analysed together. By doing this, the perspectives of the male partners together with those of the health personnel were compared to provide a critical interpretation and wholesome view of the male partner's information needs and information seeking behaviour. The results contain direct quotes in English as reported by participants except for words spoken in vernacular. With the help of a local interpreter vernacular words were translated to keep their intended meanings.

Results

Six major themes were identified pertaining to male partners experiences and needs in their involvement in pregnancy and childbirth: gender roles, antenatal involvement, care costs and delivery choices, need to be informed, dealing with emotions, and dealing with delivery day. From the theme dealing with emotions and dealing with delivery day, sub themes emerged highlighting male partners experiences during the pregnancy and delivery period.

- Gender roles

Overall, the male partners placed emphasis on the primary role expected of the traditional *Igbo man* which is to be the provider of his family. As illustrated by an expectant father,

‘I do my part like all men should, I give her money for food, I provide money to go to health centre’. (H-SS 41)

Here, the male partners reported feeling satisfied that their wives are well taken care of, because they ensure they are provided for. Some male partners strongly affirmed that both men and women have culturally defined roles that remain the same whether a woman is pregnant or not. One male partner expressed this by saying: ‘In the family everybody has his or her role. I don’t expect my wife to bring money, it’s not her duty to wash the car or change the light bulb. It is the duty of the man... when I come home, I expect her to go and prepare food’. In contrast, there were male partners who willingly shared domestic responsibilities with their spouses within the confines of their homes alone. These male partners were willing to take up extra responsibilities because they wanted to make their spouses feel loved and happy in pregnancy. Less common were reports of participants who were willing to go beyond the norm to be supportive despite the risk of ridicule by their peers. These male partners admitted to being more concerned with the wellbeing of their spouses even if they were perceived as ‘weak men’ in the eyes of the society.

- Antenatal involvement.

Antenatal involvement here refers to men accompanying their spouses to health settings for antenatal appointments. One reoccurring discussion with male partners during the interviews addressed the issue of antenatal attendance. Evident in the male partners descriptions were conflicting views of how men could be involved in antenatal care. There were men in the urban settings, who spoke about their willingness to participate occasionally in hospital settings but could not because of their jobs. Several of such male partners acknowledged dropping their spouses off for their antenatal appointments and calling often to check up on their spouses. One male partner said that he made up for his absence during the day by coming home early and taking exercise walks with his wife most evenings after work. In the rural settings, more male partners occasionally attended antenatal care appointments with their spouses

than in the urban settings. Most of these men were local transporters, owners of local businesses or farmers who acknowledged their ability to attend these sessions because they had flexible work hours. In addition, most of the men in this category, acknowledged several motivations to attend antenatal sessions which was mainly to know about pregnancy and to make their spouses happy.

We visit the clinic together because we do get information about a lot of things. Being here with her in the hospital does not mean that I don't have work to do now, but I want to make her feel happy. Seeing me around her makes her feel like she is not the only one carrying the pregnancy. (AM H1)

In contrast, there were male partners who believed that antenatal care attendance was strictly for the pregnant woman. Among these, were male partners who provided money for their spouses to register in a health setting and let their spouses manage the pregnancy with the help of other experienced women. One participant's response regarding this was:

'My wife is a very matured person in mind, she handled the pregnancy well. She had adults around her, her friends, our mothers and her sisters. She did all the consultations by herself. Sometimes, she told me about them, only if it had to do with money.' (H-FMC 9)

- Care costs and delivery choices

Occasionally male partners admitted their concerns over costs especially those associated with delivery. There was a common desire among male partners to know about the cost of care for normal and caesarean births in both public and private hospital settings. Considering that hospitals require that payments are made before care is given, the knowledge about cost was important for most to know their options and to compare costs, before deciding on which health setting to choose for delivery. In most cases, the choice of a delivery place as acknowledged by most male partners was strongly influenced by the availability of funds.

'You know money plays a very big role in deciding where your wife is going to deliver.' (FMC,001)

'Like I told you before, I had lost my job and we could not even afford to go to a hospital.... we had this maternity close to our home. That's where my wife registered.... The midwife understood our financial condition and took care of my wife properly from pregnancy until she gave birth'. (H-FMC-002)

On the other hand, there were male partners who had no worries about funding care costs. Among these were civil servants working with the government who had opted for the national health insurance scheme (NHIS). These male partners acknowledged the freedom to choose quality safe services without worrying over costs of care on the day of delivery. In addition, an uncommon conversation with a participant revealed a preference for an affordable health facility in a foreign country because he desired a safe birth and an opportunity to give his unborn child a good start in life. Here is what he said, 'When my wife's

pregnancy was confirmed, I started making plans to fly her abroad. It is a very expensive venture, but you are sure she is in good hands..... later when he grows up, he can attend a proper school there too.

- Need to be informed

Common across the male partners accounts was the feeling of ignorance concerning pregnancy and childbirth due to inexperience. Most expressed the need to be informed. Although the male partners expressed their ignorance on what to expect during pregnancy and childbirth, they preferred to handle this in a '*manly*' way by quietly seeking the opinions of people they trust or send their spouses with questions to the health centres. Often this support came from few close friends and neighbours, family members, experienced mothers, experienced colleagues, and most especially from spiritual leaders. Some male partners shared stories from the experiences of others and related these stories to their situations.

'I heard all sorts of stories about delivery. You have to pay for everything before they even touch your pregnant wife, no one will attend to you without money..... I just knew I had to start saving money. (H-SS-015)

'You know my brother's experience taught me a lot of things about pregnancy. You cannot give a pregnant woman medication no matter what. Now, if she complains about something as little as fever, we go to the hospital' (HSS-039)

Whilst some male partners acknowledged their principal support from their relationships and networks, there were others who preferred not to discuss with people in their support networks. They admitted to reading books, surfing the internet and speaking only with health professionals for their information needs. Among these were male partners who desired to keep the pregnancy news a secret. One male partner said,

'You know that this Igbo culture has made it that you don't go about telling people that your wife is pregnant. For me too, I didn't tell people. I was building information from the internet and from books and I will probably go to the hospital only when there is emergency or sickness' (H-FMC-005)

- Dealing with emotions

Feeling overwhelmed, worried and scared

Male partners voiced their feelings on how the experiences of their wives during the pregnancy and delivery affected them. Some comments such as 'the feelings this process created in me was overwhelming', 'I became very worried', 'I was so scared' reflected this. One participant feared so much for the life of his pregnant wife that he took his wife to see a doctor for an abortion.

'Honestly, I did not know that a pregnant woman can be sick and vomit continuously like that for days. After preparing delicious foods, she eats and then vomits everything. She sometimes would vomit like

she is going to die. One day I was so afraid that I told her let's go to the hospital and terminate the baby..... I told the doctor clearly that I wanted an abortion. The doctor smiled and started educating me'(H-SS-011)

Also, some male partners spoke about the unpleasantness of their spouse's changing food cravings. In his own words, a male partner said:

'Managing her cravings was a horrible experience for me.... One late evening, she demanded for Pepsi, on arrival, she demanded for malt. I had to go out again to buy that. Sometimes after cooking, she will not feel like eating anymore, she will ask me to find one roadside food for her. (H-FMC-005)

Then, there were male partners who felt differently about being around their pregnant spouses. These fathers described the emotional mood swings their spouses experienced and how irritable that made them feel. One partner admitted that 'when a woman feels this way she should be left alone'. For him, on days like that, he preferred to go out in the evening with his friends than stay at home to keep his sanity.

Being strong for their spouses

This refers to male partners need to be strong and supportive to their spouses despite their own feelings. Several male partners relayed peculiar situations where they had to be in control in other for their spouses to feel secure. Even though these men had to deal with the emotions of their own, they admitted to masking their emotions in the masculine appearances of strength and courage as is expected of men in these settings.

'She made me worry a lot when I look at her, I say every woman can give birth, but I don't know if she can because she was so fragile in my eyes..... I had to be the strong one. (H-SS 12)

Some male partners spoke about discussions they had with other men in their networks, which gave them the opportunity to see the experiences of other men in the light of their daily struggles. For many, having these types of discussions in their workplace or among 'hangout' associates, prepared them to tackle their own problems.

- Dealing with delivery day

To be present or not

During the interviews, male partners shared their thoughts about their experiences on the day of delivery. It was clear from their responses, that been present in the delivery room was not a popular opinion. Most male partners believed that the maternity ward is a strictly feminine environment, while some others were afraid of witnessing the delivery experience. A few male partners acknowledged their willingness to be present but could not because they were not given the choice to be present or involved. Here are some comments

‘they will not allow you in; I was told to stay outside. (H-LGA-1)

‘From my experience, I think all men should be in there. But you know all men will not have the mind to be in the delivery room, for those who can withstand these things, I will encourage them to attend’. (H-FMC-6)

‘I did not want to go into that room at all. I prefer to stay outside and hear the news from outside. I don’t think it will make any difference if am there or not. Some friends told me that if I go in there, I should not be surprised if my woman starts to beat me and kick me because I am the cause of her pain. (H-FMC-4)

To cover for their absence during delivery, the male partners said they ensured that an experienced woman they could trust like their sisters, mothers or mothers in law was present to help their spouses prepare for delivery and be present with their spouses during delivery. Here is what one male partner said, ‘Towards the delivery period, all I need to do is to arrange my mother or hers to come and hang around’. (H-FMC-005) The male partners referred to some activities they were involved in hospital settings such as: offering spiritual support, empathizing with their spouses, running errands, and for some they were needed to sign papers for surgeries to be performed.

Social support in health settings

The male partner’s stories especially in urban locations indicated how the presence of a friend working in the hospital or a health personnel known to them personally was important for their spouses to receive care faster especially if labour occurs at night. Some male partners voiced their feeling that their spouses might be neglected or maltreated if they do not know someone in the hospital. One male partner would rather go to a known local midwife than go to a hospital where they knew no one.

‘My friend had a bad experience at the public hospital, he got there past 10pm in the night, the doctors had deserted, the nurses were busy chatting and gossiping, his wife was in labour. He really caused a scene before they could attend to him. He told me, it had to take him calling a doctor he knew before he

could receive the appropriate assistance that night. She nearly lost her life due to their negligence'. (HSS-015)

Discussion

In this study, the experiences, views and needs of male partners regarding pregnancy and delivery in south east Nigeria was explored.

Our findings show that the perception of men as providers strongly dominated the action of male partners in this cultural setting. In Chinua Achebe's '*Things fall apart*', the *Igbo man* is culturally depicted as a strong, industrious and sole provider and protector of his home.(49). He is expected to be in control and to dominate his immediate territory (his family). Through socialization, gender norms are internalized in the mind of the '*traditional Igbo*' man from childhood. This continues to shape the perceptions of his roles into adulthood and subsequently influences his behaviour through life. In this study, the primary form of support expected of the man during pregnancy and childbirth is to provide for the needs of his family. Achieving this comes with this strong sense of satisfaction and achievement of their expected gender roles. Other supportive roles such as providing emotional, spiritual or domestic assistance were regarded as non-obligatory and secondary, responsibilities which family and friends could perform in their stead. Our findings are in agreement with other studies such as Matseke et al, which revealed that men who defined partner support as limited to giving financial help, did not endorse the view of carrying out physical tasks for pregnant women(2). Another study revealed that male partners judged their performance against their aspirations to be a 'good father' who is expected to be the provider and the protector of the home in addition to the responsibility of providing practical and emotional support to their partners.(50).

The literature supports male partners involvement in antenatal sessions, because they are better informed and prepared for their transition into parenthood(36). On one hand, very few male partners accompanied their spouses to antenatal sessions or wished to be present during delivery. Most men believed that it's not expected of them to be present with their spouses when they should be at work. However, there were men in our study who were willing to attend antenatal sessions and support their spouses during delivery. Unfortunately, most health settings in our study were more equipped to attend to women exclusively, creating an uncomfortable presence for any man who dares to be present. Other studies have reported similar findings revealing how male partners often feel excluded because the focus is mainly on the pregnant woman and the unborn child which fails to include the men as part of the process too(25,40). Hence, it is crucial that health settings revise their strategies to create alternative services for men that are inclusive, meaningful, and worthwhile within a culturally acceptable and friendly framework to encourage their involvement in maternal care. A study suggests using a male peer strategy in which men inspire other men to participate by sharing their experiences in health settings. This also agrees with the findings of Robertson, who revealed that organising male-specific sessions might be a great way to inform men because the men would tackle topics relevant to them as men and in that way are able to support each other in common areas of interest.(51)

Even though through socialization, male partners have internalized their roles in the family, our study reveals a willingness in some male partners to go beyond the norm and to carry out other feminine roles during pregnancy. For instance, some male partners would rather appear 'weak' in the eyes of the society by taking up 'feminine roles' or being present with their spouses in hospital settings. This speaks of a willingness of some male partners to be more flexible. Breaking out of the cultural shaped modes of gender roles are strong indications of changing times. The literature acknowledges this era as one marked with evolutions and changes in the social and cultural way of life of people globally. Cabrera et al revealed in their studies, that one of the prominent social trends that resonates with the 21st century is the increasing involvement of fathers in family life (34). These trends are revolutionising long standing beliefs, what is acceptable or not, in our understanding of gender roles in the family. It is perhaps not surprising that men are more flexible to discussions regarding gender roles, emotions and health, which was not the case before.

The importance of fathers' involvement during pregnancy and childbirth goes beyond their beneficial roles to the mother and child during pregnancy. Involving the father benefits the father himself for he is able to develop his identity as a parent early enough(36). Although male partners in this study eagerly anticipated fatherhood with joy, most acknowledged how unprepared they were in handling the experiences they encountered in the process. Cultural notions which excludes any show of weakness from men in these settings were strong. Therefore, male partners in this study preferred to maintain the outward look of strength for their spouses and tackle their emotional challenges quietly. This is consistent with a study among Danish men which showed that men would rather take a time out of the hospital than show vulnerability or any feelings that show that they are not in control of their emotions(52). While the men did not admit to seeking information specifically for their emotional needs, they spoke about the influence of support from their networks during some difficult times. Some male partners spoke about the support they received from people such as their religious leaders, family members, experienced friends; and how the information received influenced their choices and decisions afterwards. Although emotional and instrumental support occurred the most through face to face interactions with people in their support networks, a growing utilization of online health resources for information support was also observed in this study. More research is needed to explore this growing trend.

Conclusions And Recommendations

Our study, exploring male partners experiences, views and needs during pregnancy and childbirth has contributed to a better understanding of male partners needs in this setting. From these findings, it is evident that male partners roles during pregnancy and childbirth are strongly influenced by the indigenous culture and gender constructions of gender roles. Due to the strong influence of patriarchy, a positive and impactful strategy will require a culturally specific health intervention in teamwork with local leaders, men and local health institutions. (53). A study in a similar patriarchal setting has worked with local leaders as change agents in motivating the men in the communities and we recommend their

approach for this setting (54). We also recommend a man to man strategy because we believe that a male only information session in health settings will motivate more men to attend, while providing the opportunity to learn from each other's experiences. (54,55)

Moreover, the perspectives of pregnant women regarding attending antenatal sessions with their spouses was not explored in this study. However some studies have shown that pregnant women can discourage their spouses towards antenatal attendance due to reasons deeply embedded in the cultural perceptions of the people(9). A study in Malawi revealed how important it is for the pregnant woman to see reasons why it's important for male partners to be involved in maternal care(9). This is because there is a possibility that these informed women might coerce their spouses to attend, since they understand the impact this could have on their overall health and that of their unborn child(9). Hence, we recommend that beyond the regular check-ups, health services can turn antenatal sessions to important avenues for information dissemination to reach husbands through their spouses. Furthermore, considering that health professionals are highly revered in the society, it's possible that more men might feel more comfortable to attend these sessions with their spouses if specially invited by health professionals.

Furthermore, it is evident that a growing number of educated men in this setting utilise online resources for their questions regarding pregnancy. The importance of online support platforms has been shown in several studies. Social online communities can reach a wider audience without the limitations of time and space. And can be adapted to be interactive and offer emotional and instrumental support as well. It is important to explore this health information seeking behaviour in male partners and to discover their areas of interest and need. Similarly, local health organisations can utilise social media platforms to boost male partners engagement and to provide informational and emotional support for male partners as well.

Our next study will explore the experiences and needs of male partners from sub-Saharan origin in maternal health involvement during pregnancy and childbirth in Belgium.

Study limitations

First, majority of the men interviewed in this study had basic education (at least O levels). It is possible that interviews with uneducated men who had not accompanied their spouses would provide additional and/or different perspectives on men's experiences and needs in pregnancy and delivery.

Secondly, to reflect the impact of gender roles on male involvement, additional opinions from the spouses would have provided a richer understanding of the expected roles of men during pregnancy and delivery in these settings. In addition, within this setting, we think the men will say anything to project their being in control. Hence, a different perspective from their wives would have proven if their responses were true

of not. Further research to include mothers, wives and the family may yield a richer understanding of how family, beliefs, education influence male partners participation in pregnancy and childbirth.

Finally, although the researcher was flexible, it was challenging to find male partners who were willing to be interviewed in hospital settings and in the marketplaces. Less male partners were in the hospital because they had to work, however, in the marketplaces, the shopping streets were very rowdy, and the men were unwilling to leave their shops to be interviewed elsewhere.

Declarations

List of abbreviations used

FMC: Federal Medical Centre NHIS: National Health Insurance Scheme

Ethics approval and consent to participate

Prior to data collection, ethical approval was sought and granted by the Ethics Committee of the Hospitals Management Board for the Government of Abia State Government. (HMB/CE/72/002). Oral consent was obtained from directors of all work settings visited. Also, signed informed consent was obtained from all the participants before starting the interviews. No expenses were incurred by the participants. On the other hand, no compensation was given to any participant.

Consent for publication

Not applicable

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Authors' contributions

All the authors contributed to the various stages of this study. CO designed the study, collected, transcribed and analysed the data and prepared the manuscript. IG substantially contributed to the study design, reviewed and commented on the drafts and approved of the final version for submission.

Competing interests

The authors declare that they have no competing interests.

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