Vol. 11(8), pp. 103-109, October-December 2019
DOI: 10.5897/IJNM2019.0373
Article Number: 8C0DA4062425
ISSN: 2141-2456

http://www.academicjournals.org/IJNM

ACADEMIC JOURNALS
expand your knowledge

International Journal of Nursing and Midwifery

Full Length Research Paper

Women's perception of male involvement during pregnancy and labour in University College Hospital, Ibadan

Iyanuoluwa O. Ojo.*, Adegolarin A. Fafure and Odinaka B. Ani

Department of Nursing, University of Ibadan, Oyo State, Nigeria.

Received 21 May, 2019; Accepted 10 July, 2019

In Nigeria, male involvement practice is almost a mirage in term of labour and delivery support among women. In spite, of it help at reducing complications. The aim of the study is to assess perception of different tribes towards male involvement during pregnancy and labour, the educated, non educated, employed, unemployed and perceived barriers respectively. A descriptive cross-sectional research design was employed. Self structured questionnaires were used to elicit information. Descriptive statistics were used to present results and hypotheses tested with chi square P≥ 0.05. Majority of the respondents were Yoruba (91%) and they had a good perception. Furthermore, (94%) of the educated had good perception and (57%) employed respondents had a good perception. About, 48.6% of the respondents opined that major barrier to male involvement is lack of adequate infrastructure. Therefore, there is a great need to address infrastructure and hospital policy, that will in turn lead to a good outcome for labour in women.

Key words: Male involvement, perception, labour, pregnancy.

INTRODUCTION

According to World Health Organization 2015 statistics, the maternal mortality ratio in developing countries is 239 per 100 000 live births and this is attributed to complications of pregnancy and childbirth characterized by pain and other delivery related complications (Alkema, 2016). A disproportionately high burden of these deaths is borne by developing countries particularly Nigeria where the maternal mortality and morbidity rates have remained one of the highest globally (World Health Organisation (WHO), 2015). Data shows a daunting maternal mortality ratio of 1500/100,000 births in Nigeria accounting for nearly 15% of the global estimates of maternal mortality (WHO, 2015). This situation is aggravated due to inadequate management of pregnancy and labour, which does not only inflict psychological and physical hardship on parturient women; but essentially bugs the health-care system with huge financial burden (Alkema et al., 2015). Childbirth pain whether triggered by medical or non-medical causes can make women feel uncomfortable and anxious and become sleepless and agitated. Such pain also stimulates the sympathetic nervous system which causes increase in the heart rate, blood pressure, sweat production, endocrine hyper function, and delays in prognosis (Ebirim et al., 2013).

*Corresponding author. E-mail: adubiiyanu@gmail.com.

As such, a pharmacological or non-pharmacological intervention of a sort is required to alleviate parturient pain. Support for women during labour is a common phenomenon in many parts of the world, while in most developing countries such support from a man is considered as a sign of weakness based on cultural beliefs. In different parts of the world, most especially in developed countries such as UK and Denmark, male involvement is a common practice during labour and delivery with about 95% attendance (Emelonye et al., 2017). Studies conducted in these developed countries show that women who had continuous spousal labour support are reassured, comforted and emotionally encouraged to overcome pain associated with labour and delivery (Aziato et al., 2017).

Furthermore, a similar review has shown that women with continuous support by spouses also experience shorter labours, reduced need for oxytocin, anaesthesia, analgesia, instrumental deliveries and have less than 50% chance of being admitted to a cesarean section (Bohren et al., 2017). The effect of support is more remarkable if the support role is adopted by a spouse rather than a caregiver that is also providing medical care (Vehvilainen-Julkunen and Emelonye, 2014). Another study focusing on the attitude and preferences of pregnant respondents about social support during labour and childbirth found that the pivotal role men play providing support during labour improves delivery outcome for both the mother and her newborn (Lewis et al., 2015). They are also considered to be critical partners for improvement of maternal health-care in Nigeria (Iliyasu et al., 2010). Even though these benefits accrue from the participation of spouse in labour and delivery, it has not yet found its place in the Nigerian maternal health-care system (Vehvilainen-Julkunen and Emelonye, 2014).

In furtherance, studies showed different proportions of male involvement in choice of delivery site. For instance, in Ethiopia one study established high involvement (90.4%) (Wassie et al., 2014). In Uganda, a study in the south western region indicated that 56% of male partners were involved in deciding spouses' place of delivery (Kabakyenga et al., 2012). Other studies have reported negative perceptions towards men attending Antenatal Clinic services (Ganle and Dery, 2015; Maluka and Peneza, 2018).

Studies have shown that lack of knowledge about maternal health pose a significant challenge to positive male partner involvement (Nesane et al., 2016). Other factors found to hinder the actualization of this desire for males to be involved in labour include education, which has been shown in some studies as a determining factor, reporting high participation of educated men in supporting their wives during antenatal and delivery sessions than uneducated men (Vehvilainen-Julkunen and Emelonye, 2014). Other factors such as ignorance, poverty, cultural and religious practices were shown to be reasons for low spousal participation during delivery (Lowe, 2017). In Nigeria where culture and religion governs the practices of the society, there is a strong cultural belief in several parts of the country that spousal presence worsens labour pain and prolongs labour (National Population Comission, 2013). It has also been noted that in some instances, spouses are subtly dissuaded from participating in labour by unfriendly hospital settings and staff or through unequivocal inscriptions on the labour ward door such as "you are not needed here" (Iliyasu et al., 2010).

Although the World Health Organization (WHO, 2018), recommends the practice whereby parturient women are allowed to have a birth companion of choice, the reverse is obviously the practice in Nigeria, where practices contrary to the recommendations of the World Health Organization that parturient women be encouraged to undergo labour and delivery with the support of a companion they trust and feel at ease with WHO (2018). While noting the positive maternal experiences of wives in developed countries due to spousal support and participation during labour and delivery, the poor state of the practice in Nigeria therefore demands immediate further research, hence the need to determine women's perception of male involvement during pregnancy and labour in University College Hospital, Ibadan.

MATERIALS AND METHODS

Study design

A descriptive cross-sectional study was employed in the study to assess women's perception of male involvement during pregnancy and labour in University College Hospital, Ibadan (UCH). This study design is imperative because it was able to measure the factors under investigation.

Study setting

This study was carried out in the ante-natal clinic of the University College Hospital Ibadan. UCH is in Ibadan North Local Government of Oyo State, Nigeria. There are 56 service and clinical departments with 96 consultative outpatient clinics in 50 speciality and subspecialty disciplines. In addition, the hospital houses virus research laboratory, a World Health Organisation Collaborating Centre, special treatment clinic and pharmacy department. The hospital comprises over 66 wards and 1000 beds. The average numbers of pregnant women that visited antental clinic in UCH for the month of July, 2018 was 120. The study was conducted among pregnant women attending ante-natal clinic of University College Hospital, Ibadan.

Sampling technique

Accidental sampling technique was used to select 128 available participants who met the eligibility criteria. The researcher used participants met at the antenatal clinic without randomisation and questionnaire was administered to them. Data were collected using Self administered structured questionnaire which was developed after an extensive literature review. However, only 105

questionnaire were suitable for analysis.

Instrument for data collection

An interviewer-administered structured questionnaire was used to collect relevant information from the respondents. The instrument was made up of three sections. Section A collected information about the socio-demographic characteristics of the respondents, Section B collected information about perception of pregnant women towards male involvement while Section C collected information about enabling factors / barriers to male involvement.

Ethical considerations

An ethical approval was obtained from Ethical Review Board of University of Ibadan/ University College Hospital Ibadan. The approval number NHREC/05/01/2008a. Also, the respondent's informed consent and participation was on voluntary basis. Furthermore, introductory letter was obtained from the medical health officer in charge of the department to facilitate the process of data collection and to meet designed protocols. The collected information was kept confidential and no identifiers were included in the questionnaires.

Statistical analysis

The data obtained was entered into the spread sheet, and analysis was done using the Statistical Package of Social Sciences version 22.0. Descriptive statistics such as frequency, percentage representations, was used to present the result. Inferential statistics such as chi- square test was used to determine significant association between the variables.

RESULTS

Socio-demographic characteristics

Table 1 shows the demographic data of the participants. Results from the study indicate that the largest percentage of the respondents, 93.3% are married, most of the respondents' current level of education is the tertiary level, 80.0 and 93.9% are from the Yoruba ethnic group. Also, 58.1% of the respondents are employed while 37.1% had given birth to two children in the past.

Perception of educated and non-educated women on male involvement

Table 2, the study reviewed that ninety-four of the one hundred educated respondents have a good perception while only five of the uneducated respondents have a good perception towards male involvement during pregnancy and labor.

Perception about the inter-tribal groups towards male involvement during pregnancy and labor

Table 3, the findings reflect that ninety-one of the respondents from the Yoruba tribe have a good perception as compared to other tribes such as Igbo, Hausa and Edo about male involvement during pregnancy and labor.

Perception of the employed and the unemployed women towards male involvement during pregnancy and labour

Table 4, It was observed that fifty-seven of the sixty-one employed respondents have a good perception towards male involvement during pregnancy and labor.

Enabling factors and perceived barriers towards male involvement

Table 5 result revealed that majority of the respondents, 27.6% strongly agreed that lack of facilities or infrastructure to favour the presence of their husbands during the delivery process is a major barrier to their involvement. Also, 24.8% of them strongly agreed that hospital policies hinder participation of men in the labour process.

TEST OF HYPOTHESIS

There is no significant association in the perception of the educated and the uneducated women on male involvement during pregnancy and labour

Table 6 shows statistically that there is no significant association in the perception of educated and uneducated women on male involvement during pregnancy and labour (X_2= 0.318, df=1 and P value greater than 0.05).

There is no significant association in the perception of women from different tribes on male involvement during pregnancy and labour

Table 7 shows that in the chi-square test result, there is no significant association in the perception of women from different tribes on male involvement during pregnancy and labour (X_2=0.525, df = 3 and P value greater than 0.05).

There is no significant association in the perception of the employed and the unemployed women on male involvement during pregnancy and labour

Table 8 shows that in the chi-square test result, there is no significant association in the perception of employed women and unemployed women on male involvement during pregnancy and labour (X_2=0.146, d_f = 1 and P value greater than 0.05).

Table 1. Socio-demographic data (n= 105).

Variables	Frequency	Percentage
Educational status		
Primary	2	1.9
Secondary	16	15.2
Tertiary	84	80.0
None	2	1.9
No response	1	1.0
Employment status		
Working class	61	58.1
Full housewives	44	41.9
Number of children		
One	28	26.7
Two	39	37.1
Three	12	11.4
Four	3	2.9
Five	1	1.0
None	22	21.0
Marital status		
Single	7	6.7
Married	98	93.3
Religion		
Christianity	70	66.7
Islam	33	31.4
Others	2	1.9
Ethnicity		
Igbo	5	4.7
Hausa	1	0.09
Yoruba	99	93.9

Table 2. Perception of the educated and the uneducated women on male involvement during pregnancy and labor.

Respondents' perception	Level of Education		Total
	Uneducated	Educated	
Poor perception	0	6	6
Good perception	5	94	99
Total	5	100	105

DISCUSSION

Socio demographic data

The study assessed women's perception of male involvement during pregnancy and labour. The study showed that the largest percentage of the respondents, are married, most of the respondents' current level of education is the tertiary level, and are from the Yoruba ethnic group.

Perception of educated and non-educated, inter-tribal groups, employed and the unemployed women towards male involvement during pregnancy and labour

The result showed that a lot of women who were uneducated had a poor perception of male involvement in labour. It can therefore be deduced that education is a determinant of women's perception towards male involvement. In addition, low level of education may also

Table 3. Perception among inter-tribal groups towards male involvement during pregnancy and labor.

Respondents' perception		Ethnicity				Total
		Igbo	Hausa	Yoruba	Edo	
Perception	Poor perception	0	0	6	0	6
	Good perception	5	1	91	2	99
Total		5	1	97	2	105

Table 4. Perception of the employed and the unemployed women towards male involvement during pregnancy and labor.

Respondents' perception		Are you employed?		Total
		Yes	No	
Perception	Poor perception	4	2	6
	Good perception	57	40	97
Total		**61**	**42**	**103**

Table 5. Enabling factors and perceived barriers towards male involvement.

Statement	SD Freq(%)	D Freq(%)	N Freq(%)	A Freq(%)	SA Freq(%)
The hospital policy hinders my husband from being present during the delivery process	25(23.8%)	32(30.5%)	12(11.7%)	10(9.5%)	26(24.8%)
There are no facilities or infrastructure that favour the presence of my husband during the delivery process and antenatal visit	21(20%)	27(25.7%)	6(5.7%)	22(21.0%)	29(27.6%)
The attitude of health professionals discourages my husband from accompanying me to the clinic	27(25.7%)	37(35.2%)	8(7.9%)	13(12.4%)	20(19.0%)
The environment is not conducive for my husband to partake in my care	17(16.2%)	40(38.1%)	5(4.8%)	18(17.1%)	25(23.8%)
My culture does not encourage my husband's presence during labour	55(52.4%)	31(29.5%)	5(4.8%)	5(4.8%)	9(8.6%)
My religion doesn't allow my husband's presence during labour	52(49.5%)	38(36.2%)	0(0%)	6(5.7%)	9(8.6%)
My husband does not see any reason why he should accompany me to the health centre	52(49.5%)	28(26.7%)	4(3.8%)	10(9.5%)	11(10.5%)

Footnote. SD: Strongly disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree.

distort comprehension and communication of health messages to their male partners. This is consistent with results of studies done in Uganda (Kabakyenga et al., 2012) in Kenya, (Wanjira et al., 2011), in Senegal (Dia, 2014) and in Tanzaniza (Maluka and Peneza, 2018). However, it differs significantly with studies conducted in Kenya (Kenya National Bureau of Statistics, 2008) and in Ethiopia (Wassie et al., 2014). Education has been shown in many studies as a determining factor reporting high participation of educated spouses of above 50% accompanying their spouses to the antenatal clinic and delivery room than uneducated men (Vehilainen-Julkunen and Emelonye, 2014). It was common practice that nearly all husbands (97.4%) encouraged their wives and pay for antenatal service bills, however only 63.9% were actually present at the delivery. Even though the study shows that more than 50% of men participated in the delivery process, their participation was linked

Table 6. There is no significant association in the perception of the educated and the uneducated women on male involvement during pregnancy and labour.

	Value	D.f	P-value
Perception of educated versus perception of uneducated	0.318	1	0.629

Table 7. There is no significant association in the perception of women from different tribes on male involvement during pregnancy and labour.

	Value	D.f	P-value
Perception of women of different tribes	0.525	3	0.913

Table 8. There is no significant in association the perception of the employed and the unemployed women on male involvement during pregnancy and labour.

	Value	D.f	P-value
Perception of employed vs unemployed	0.146[a]	1	0.702

strongly to their educational background. On the other hand, most uneducated men in Nigeria think that their presence are not necessary during delivery, but rather restricted to only the duty of providing financial support for their spouses (Vehilainen-Julkunen and Emelonye, 2014). Thus, education of both males and females must be put into consideration in the development of policies and strategies to increase male participation in labour.

Enabling factors and perceived barriers towards male involvement

Further, majority of the respondents implicated hospital policy and lack of facilities or infrastructures as barriers to their husband's involvement in the antenatal, intra-natal and postnatal periods. It can therefore be deduced that since more than half of the respondents felt the infrastructure and environment is not conducive for their husbands, they would definitely discourage them from coming into the labour room. A study by Maluka and Peneza (2018), revealed that health facilities have unfavorable environment for men's participation during delivery. For example, the physical infrastructures hampered male participation in maternal and child health in the study. It was evident from the findings that due to the nature of delivery rooms, men were not allowed in the labour room. The health system attempts to protect the privacy of other women because the delivery room is structured in a way that contains many delivery beds and there are always other women in the room. Lack of space to accommodate male partners during delivery has been reported to deter participation of men in pregnancy and childbirth in several other studies conducted in different countries (Ganle and Dery, 2015; Maluka and Peneza, 2018; Bohren et al., 2014). These findings therefore support results from this study, and thus calls for effective action by all involved, in order to improve outcome for the woman and her child. Other barriers were also assessed such as the attitude of health care workers, religion and culture but majority of the women did not perceive this as a barrier to male involvement. This therefore shows an improvement in the barriers to male involvement over the years as studies carried out by Iliyasu et al. (2010), NPC snd ICF (2013) and Lowe (2017) revealed that attitude of spouses toward husband's participation in maternal care is strongly opposed to the physical presence of husbands in the labour room during delivery due to the strong cultural and religious effects, especially for Muslims. It was however, noted that Christians were more inclined to spousal participation in antenatal and post-natal care (Umeora et al., 2011 as cited in Vehvilainen-Julkunen and Emelonye, 2014). There is therefore a need to further encourage male participation in labour, especially mitigating the effects of religion, culture and ethnicity, in order to improve prognosis for parturient women.

Implication of the findings to nursing

This study has pointed out the fact that majority of the pregnant women want their husbands to be involved in antenatal, intra-natal and post natal care. Likely barriers such as religion culture educational status were ruled out. However, lack of adequate infrastructure and conducive environments served as barriers to male involvement. It is therefore imperative for nurses and midwives to explore participation of males in the labour process, and use this as a means to reduce intra partum pain and lessen their work. They should also serve as advocates

in influencing hospital policies to integrate males into the process of labour and delivery.

Conclusion

Male involvement in antenatal care, intra-natal and post natal care has been of utmost importance but little has been said or done about it in Nigeria. This study therefore identified women's perception towards males' involvement in labour and found barriers to male involvement to include poor infrastructures and inappropriate hospital policies.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations have been put forward:

(i) The hospital should have a written policy as regards male involvement and make it known to the pregnant women and staff of the hospital.
(ii) The hospital management should build structures that favour male involvement in antenatal, intra-natal and postnatal care.

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

REFERENCES

Alkema L, Chou D, Hogan D, Zhang S, Moller AB, Gemmill A, Fat DM, Boerma T, Temmerman M, Mathers C, Say L (2015). Spousal Presence as a Nonpharmacological Pain Management during Childbirth: A Pilot Study Nursing Research Practice. Lancet. 2016; 387(10017):462-74. doi: 10.1155/2015/932763

Aziato L, Acheampong AK, Umoar KL (2017). Labour pain experiences and perceptions: a qualitative study among post-partum women in Ghana**.** BioMed Central Pregnancy Childbirth 17:73.

Bohren MA, Hofmeyr G, Sakala C, Fukuzawa RK, Cuthbert A (2017). Continuous support for women during childbirth. Retrieved from https://www.cochrane.org/CD003766/PREG. Accessed 20/6/2019

Bohren MA, Hunter EC, Munthe-Kaas HM, Souza JP, Vogel JP, Gülmezoglu AM (2014). Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. Reprod Health 11(1):71.

Ebirim LN, Buowari OY, Ghosh S (2012). Physical and psychological aspects of pain in obstetrics. In Pain in Perspective. IntechOpen.

Emelonye AU, Vehviläinen-Julkunen K, Pitkääho T, Aregbesola A (2017). Midwives perceptions of partner presence in childbirth pain alleviation in Nigeria hospitals. Midwifery 48:39-45.

Ganle JK, Dery I (2015). 'What men don't know can hurt women's health': a qualitative study of the barriers to and opportunities for men's involvement in maternal healthcare in Ghana. Reproductive Health BioMed Central 12:93.

Kabakyenga JK, Ostergren PO, Turyakira E, Pettersson KO (2012). Influence of birth preparedness, decision-making on location of birth and assistance by skilled birth attendants among women in south western Uganda, PLOS ONE 7:4.

Kenya National Bureau of Statistics (2008). Kenya Demographic and Health Survey 2008 report Calverton, 2009; Maryland, USA.

Lewis S, Lee A, Simkhada P (2015). The role of husbands in maternal health and safe childbirth in rural Nepal: a qualitative study. BMC Pregnancy and Childbirth 15(1):162.

Lowe (2017): Social and cultural barriers to husbands' involvement in maternal health in rural, Gambia the Pan African Medical Journal 27:255.

Maluka SO, Peneza AK (2018). Perceptions on male involvement in pregnancy and childbirth in Masasi District, Tanzania: a qualitative study. Reproductive Health 15(1):68.

National Population Commission (NPC) Abuja, Nigeria: NPC and ICF Macro (2013). [Last cited on 2013 Apr 31]. Nigeria demographic and health survey 2008. Nursing Research and Practice 1:63.

Nesane K, Maputle SM, Shilubane H (2016). Male partners' views of involvement in maternal healthcare services at Makhado Municipality clinics, Limpopo Province, South Africa. African Journal of Primary Health Care and Family Medicine 8(2):1-5.

Umeora OU, Ukkaegbe CI, Eze JN, Masekoameng AK (2011). Spousal companionship in labour in an urban facility in South East Nigeria. Anatolian Journal Obstetrics Gynecology 2:1

Vehviläinen-Julkunen K, Emelonye AU (2014). Spousal Participation in Labor and Delivery in Nigeria. Annals of Medical Health Sciences Research 4(4):511-515.

Wanjira C, Mwangi M, Mathenge E, Mbugua G, Ng'ang'a Z (2011) Delivery practices and Associated Factors among Mothers Seeking Child Welfare Services in selected Health Facilities in Nyandarua South District, Kenya. BMC Public Health 11:360.

Wassie L, Bekele A, Ismael A, Tariku N, Heran A, Getnet M, Mitike M, Adamu A, Seifu H (2014). Magnitude and factors that affect males' involvement in deciding partners' place of delivery in Tiyo District of Oromia Region, Ethiopia. Ethiopia. Journal of Health Development (Special Issue 1).

World Health Organisation (WHO) Reproductive Health Library (2018). WHO recommendation on companionship during labour and childbirth (February 2018). The WHO Reproductive Health Library; Geneva: World Health Organization.

World Health Organisation (WHO) (2015). Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group.