

Male involvement in promotion of safe motherhood in Low- and Middle-Income Countries: A Scoping Review

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Abstract

BACKGROUND: Maternal health programmes that focus on the woman alone are limiting in LMICs as pregnant women often relate to maternity services through a complex social web that reflects power struggles within the kinship and the community. **METHODS:** A scoping review was conducted to explore the rationale for male involvement in maternal health in LMICs. This review was guided by the question: What is the current state of knowledge regarding the inclusion of men in maternal health services in LMICs? The literature search was conducted using mySearch, Bournemouth University's iteration of the EBSCO Discovery Service (EDS) tool. The review process used the Preferred Reporting Items for Systematic Reviews to select papers for inclusion. **FINDINGS:** Thirty three studies met the inclusion criteria. Findings describe the rationale for involving men in maternity care, alongside the criticisms and challenges inherent in engaging with men in maternal health. Involving men in maternity services can improve health outcomes for women and infants. Health strategies aimed at educating men are relevant in equipping men with knowledge and skills that help men to be supportive of women's wellbeing during pregnancy and childbirth. **CONCLUSION:** Men can serve as advocates for women and reinforce their partner's choices in accessing skilled care and infant feeding. Further research is required to examine the effect of male involvement on women's autonomy and to assess health education interventions aimed at mitigating harmful outcomes of involving men in maternity services.

Introduction

This paper presents a scoping review of male involvement in safe motherhood in Low-and-Middle Income Countries (LMICs). It describes the rationale for involving men in maternity care, criticisms and challenges inherent in engaging with men to promote safe motherhood. The term 'male involvement' used interchangeably with 'male participation' in this study may be used to refer to several actions that a man could take up to support and protect the health of his pregnant partner (often his wife) and children, such as making informed decisions with his spouse regarding Human Immunodeficiency Virus (HIV) prevention, nutrition, workload during pregnancy, attending antenatal care, birth preparations, delivery and postpartum period (Kamal 2002; Fayemi et al. 2011). Safe motherhood alludes to a combination of initiatives, programmes and services aimed at enabling women safely to go through pregnancy and childbirth such as education on safe motherhood, maternal nutrition, skilled care, emergence obstetric care and postnatal care (UNFPA 2004).

Male involvement in maternal health is important in LMICs as maternal mortality is still a challenge despite several initiatives to promote safe motherhood. Maternal health programmes focusing on women exclusively have used several strategies such as; empowerment, autonomy, health education and skilled care in a bid to improve health outcomes (WHO 2012). However, programmes that focus on the woman alone are limiting as pregnant women often relate to maternity services through a complex social web that reflects power dynamics within the kinship and the community (Jegade 2009; WHO 2012). Women's low status in patriarchal settings has placed considerable limitations on their ability to access education, economic opportunities and health services (Varkey et al. 2004). Decisions to seek care are determined by men and or mother-in-law who have control over financial resources, and this influences factors such as organising transport to reach a health facility and making decisions on whether a woman can be referred to a higher-level facility in the case of complications (Dutta et al. 2004; Magoma et al. 2010). The socio-cultural context of women in LMICs reinforces the need for maternal health programmes to focus on both the woman and her spouse/partner in order

to improve health outcomes and or promote safe motherhood. The knowledge and skills women gain during maternal health education can be applied when women receive support from immediate family such as husbands, mothers, mothers-in-law and other relatives (Sahip and Turan 2007). It is worth noting that men are interested in the welfare of their families and could respond positively to efforts to involve them in maternal health (Sternberg and Hubley 2004). A systematic review on involving fathers in neonatal units observed that supporting the father-baby bond and co-parenting among couples improved infant health through oxygen saturation, increased rates of breastfeeding and enhanced weight gain (Fisher et al. 2018). Fathers in this study described the experience of skin-to-skin care of their babies with expressions of love, excitement and happiness (Fisher et al. 2018). Male involvement in maternal health has the potential to address gender related influences impeding on safe motherhood. For instance, working with men and women enables programmes to influence social relationships, challenge harmful norms around masculinity, parenting and patriarchal structures contributing to poor maternal outcomes (Comrie-Thomson et al. 2015). A study from Uganda indicates that women are interested in greater male involvement in maternal health beyond the traditional roles on decision making and financial support (Singh et al. 2014). Male participation in maternal health in LMICs varies from country to country and or local context. For instance, a study conducted by Jennings et al. (2014) compared levels of male participation in antenatal clinics in eight African countries ranging from a high of (86.8%) in Rwanda and lowest in Burundi at (18.2%). This review set out to determine the current state of knowledge regarding the inclusion of men in maternal health.

Review Methods

A scoping review was conducted to explore the rationale for male involvement in maternal health in LMICs. This review adapted the preferred reporting items for systematic reviews and meta-analyses extension for scoping reviews (PRISMA-ScR) checklist (Tricco et al. 2018). Scoping reviews are useful for answering questions that are broad in scope (Tricco et al. 2018) as it was the case in this study. Tricco et al (2018) suggests that scoping reviews can be conducted to meet objectives examining the extent, range and nature of the evidence on a topic or question and summarise findings from a body of knowledge

that may be heterogenous in methods and or discipline. This review was guided by the question: What is the current state of knowledge regarding the inclusion of men in maternal health services in LMICs? The review had two objectives to: (a) elicit the rationale for engaging men in maternal health services; and (b) explore the challenges of male involvement in maternal health. This was framed as a PICO:

Study population: women, men, health workers, communities

Intervention: male involvement during pregnancy, childbirth and after birth

Context: Low- and middle-income countries

Search terms

The literature search was conducted using mySearch, Bournemouth University's iteration of the EBSCO Discovery Service (EDS) tool. This enabled the simultaneous and systematic searching of multiple bibliographic databases, including CINAHL, Cochrane Review, MEDLINE, SOCINDEX and Web of Science. Additional studies were identified through hand searching and snowballing such as reviewing reference lists of papers included in the review and organisational websites. Filters for the search strategy included: publications in English and from 1994 to May 2019. The start date was chosen to reflect the fact that global efforts to involve men in maternal health were scaled up after the International Conference on Population and Development held in Cairo, Egypt in 1994 (UNFPA 2004). Key words used in various combinations included: `male involvement`, `male participation`, `men`, `strateg*`, `husband`, `spouse`, `pregnancy`, `antenatal care`, `labo*r`, `childbirth`, `maternal health` and `Low and Middle-Income Countries`. A framework developed by the Cochrane database for systematic reviews known as population, intervention, comparison or context, outcome (PICO) was used to guide the literature search (Bettany-Saltikov 2012). In more observational studies Co may be used to represent context. The review process used the Preferred Reporting Items for Systematic Reviews (PRISMA) to select papers for inclusion summarised in Figure 1.

Data extraction

The study selection and data extraction process included: study setting, population, study design, intervention, and results on involving male partners in maternal health. Data extraction was performed by the first author, evaluating titles, abstracts, and full text papers which were discussed by all the three authors of the study. Additionally, independent searches and extraction were carried out by two authors and results discussed as a team. Disagreements on study selection and extraction were resolved by consensus and discussion.

Included studies

The scoping review included all study types, peer reviewed papers and reports to get a broad picture of the current state of knowledge regarding male involvement in maternity care. In addition, papers were included if they were written in English between 1994-2019, involved human subjects and focussed on male involvement in maternal health. Excluded papers were papers not written in English, non-maternity related papers and initiatives/women stand alone initiatives/programmes.

Data synthesis

The purpose of the analysis was to get an overview of the existing studies. Therefore, a narrative description of synthesised findings (Siddaway et al. 2019) has been presented due to the heterogeneity in study setting, study design and outcome variables in the included studies.

Results

Table 1 provides a summary of study characteristics of papers included. The study designs of papers included: six were reviews (Thaddeus and Maine 1994; Davis et al. 2012; Morfaw et al. 2013; Yargawa and Leonard-Bee 2015; Tokhi et al. 2018; Aliyu et al. 2019); one report (UNICEF 2007); seven quantitative papers (Mullany et al. 2007; Midhet and Becker 2010; Mushi et al. 2010; Tweheyo et al. 2010; Turan et al. 2011; Jennings et al. 2014; Forbes et al. 2018). Most studies (sixteen) in this review were qualitative papers (Desclaux and Alfieri 2009; Traore et al. 2009; Magoma et al. 2010; Maman et al. 2011;

Kululanga et al. 2012; Kaye et al. 2014; Singh et al. 2014; Ganle and Dery 2015; Ladur et al. 2015; Lewis et al. 2015; Ganle et al. 2016; Aborigo et al. 2018; Chimatiro et al. 2018; Mkandawire and Hendriks 2018; Peneza and Maluka 2018; Sharma et al. 2018). Three papers were mixed methods studies (Mullick et al. 2005; Iliyasu et al. 2010; Onchong`a et al. 2016). Most of the individual studies were from low income countries; four from west Africa (Traore et al. 2009; Ganle and Dery 2015; Ganle et al. 2016; Aborigo et al. 2018); six from Southern Africa (Mullick et al. 2005; Maman et al. 2011; Kululanga et al. 2012; Ladur et al. 2015; Chimatiro et al. 2018; Mkandawire and Hendriks 2018); six from East Africa (Magoma et al. 2010; Tweheyo et al. 2010; Turan et al. 2011; Kaye et al. 2014; Forbes et al. 2018; Peneza and Maluka 2018) and four from South Asia (Mullany et al. 2007; Midhet and Becker 2010; Lewis et al. 2015; Sharma et al. 2018). One study had multi-country sites in Africa and South Asia (Desclaux and Alfieri 2009; Jennings et al. 2014).

Social context in which women live in LMICs

Six papers described the influence of social context on women`s access to maternity services (Thaddeus and Maine 1994; UNICEF 2007; Acharya et al. 2010; Magoma et al. 2010; Midhet and Becker 2010; Lewis et al. 2015). The rationale for male involvement in maternity care is explored through the lens of social context in which women live and broad benefits of male involvement in maternal health. Considering women`s position and social status in patriarchal settings, there has been a need for maternal health programmes to work with couples and or men whilst promoting the interests of individual women within these settings.

Thaddeus and Maine (1994) suggests that women`s social status within a given society shapes health seeking behaviour/access to maternal health services. It is worth noting that social status comprises of the educational, cultural, economic, legal and political position in a society (Thaddeus and Maine 1994). Women`s low status and or dependency on men arise from cultural values, gender roles, lack of education, place of residence (rural vs urban) and lack of economic capabilities (Acharya et al. 2010). Men serve as gatekeepers to women`s health through decision making on matters regarding finances, nutrition in pregnancy, place of delivery, referral to higher level health facilities

and infant care (Acharya et al. 2010; Magoma et al. 2010; Lewis et al. 2015). An extract from the paper by Thaddeus and Maine (1994, p.9) illustrates this; “Women do not decide on their own to seek care: the decision belongs to a spouse or to a senior member of the family...” For instance, in Burkina Faso, Mali and Nigeria, almost 75% of women reported that husband`s alone made decisions about women`s healthcare whilst in Bangladesh and Nepal, the figure was about 50% (UNICEF 2007). In addition, social norms embedded in culture may discourage unaccompanied women from leaving home and or those that require women to inform close family relations on movements restrict women`s mobility even in situations where women can influence household decisions on medical care thereby causing delays in accessing maternal health services.

Men play an important role in advocating for shared decision-making amongst couples/families as well as speaking out against norms that contribute to inequities in society. Midhet and Becker (2010, p.2) suggest that men (husbands)

“can help reduce maternal mortality and morbidity by a) encouraging and facilitating their wives` use of prenatal care; b) ensuring better nutrition and rest for their wives during pregnancy and the postpartum period; c) arranging for a skilled birth attendant for delivering the baby; d) preparing for the possibility of obstetric emergencies by arranging transportation and finances; and d) reducing the delay in the decision to seek medical care in case of obstetric emergencies”.

Benefits of male involvement in maternal health

Mullick et al. (2005) highlighted the need to view men as recipients of maternal health services who may require practical information on pregnancy and or birth preparations and mechanisms to support their spouses. This same study also reported that efforts to engage with men can positively influence a couple`s communication, postpartum visits and provide an opportunity for health workers to provide vital information to their partners on maternity care (Mullick et al. 2005). A similar study conducted in South Africa reported on women`s description of men`s roles in maternal health such as facilitating access to health facilities, support while they waited at antenatal clinics, emotional support, infant feeding and provision of finances for food and infant care (nappies, clothes, formula milk)

(Maman et al. 2011). Mersha 2018 observed that male involvement in making birth plans and complication readiness was found to be positively associated with knowledge of obstetric danger signs during pregnancy, labor and postpartum period. Awareness of danger signs enables couples to anticipate and/or prepare to lessen complications during pregnancy and childbirth. A randomised control trial (RCT) in Nepal reported women who received education with husbands during antenatal care sessions were more likely to make birth preparations and attend postnatal visits compared to the control group women (Mullany et al. 2007). Forbes and colleagues (2018) described the effect of men's physical appearance at antenatal clinics as one that was associated with higher uptake of screening services (urine and blood samples) and health information on complications in pregnancy. Forbes et al. (2018) also noted the behaviour of health providers towards couples seeking maternity services to be different and attributed it to gender roles accrued to men as head of a household thereby requiring more information and or ability to pay for screening tests accordingly. It is worth noting that this study did not find an association between male involvement and early antenatal care attendance among pregnant women in Ethiopia.

Involving partners of pregnant women in maternal health has been shown to improve uptake of skilled birth attendants and health facility deliveries in LMICs (Magoma et al. 2010; Tokhi et al. 2018). For instance, a systematic review in LMICS showed that male involvement during pregnancy and postnatal care was significantly associated with improved utilisation of skilled birth attendants and reduced odds of postpartum depression (Yargawa and Leonardi-Bee 2015). Whilst a community-based intervention targeting men and women in Eritrea with maternal health education observed a significant increase in health facility births from about 3% to 47% in the intervention group over a period of nine months (Turan et al. 2011). This same study also reported an increase in uptake of antenatal care from 18% to 80% ($p < 0.001$) and a decrease in the proportion of women reporting birth or infant related complications from 34% to 13% ($p < 0.001$) (Turan et al. 2011). A before-and-after study conducted in Tanzania reported a significant increase in uptake of skilled birth attendants from 34.1% to 51.1% ($p < 0.05$) suggesting the effectiveness of a safe motherhood programme targeting pregnant women and male partners/family (Mushi et al. 2010). Midhet and Becker (2010) observed improvements in

pregnant women`s diet, reduced workload and increased health facility visits after their husbands were provided with health information on maternal health in Pakistan. A study conducted in rural Malawi described the importance of involving men in maternal nutrition to facilitate healthier pregnancies and babies (Mkandawire and Hendriks 2018). Nutrition education during antenatal clinics is carried out routinely in Sub-Saharan Africa to address nutritional disorders such as anaemia arising from a cultural diet rich in carbohydrates but lacking fruits and vegetables. Involving men in maternal nutrition facilitates changes in the cultural diets as men learn of the benefits of a balanced diet and are able to support pregnant women from an informed position,

“we learn together with women. They tell us that expectant women are not supposed to do very tiresome work. They need to eat different food groups like milk, meat, eggs, beans, vegetables and fruits...then we try as much as possible to give it to her at home” (Mkandawire and Hendriks 2018, p.6).

In contrast, men who are uninformed of the importance of nutrition in pregnancy maybe problematic and or resist implementation of nutritional messages learnt during antenatal care sessions by women as reported by Aborigo et al;

“a woman went for weighing [antenatal care] and she was told the type of foods to eat. When she got home and told her husband, the man asked her to go back to the hospital for those foods. If the man had gone with his wife to the clinic, he would have also heard the type of foods his wife should eat. It would have been more helpful” (2018, p.5).

It is possible that men can be involved in providing resources to support good nutrition at home and encourage pregnant women in adopting healthier diets thereby impacting on positive maternal health outcomes. Men can support their partners in adhering to preferred infant feeding practices such as formula feeding or exclusive breast feeding. A study on infant feeding practices in Burkina Faso, Cambodia and Cameroon highlighted the role played by fathers/male partners in supporting their wife`s decision to use either replacement feeding or exclusive breastfeeding and/or early weaning for their infants (Desclaux and Alfieri 2009). This study was conducted within the context of Prevention of Mother-to-Child Transmission (PMTCT) programme at a time where health workers

provided women with two infant feeding alternatives either to exclusively breastfeed their infants for a short time or use formula feeding. Women, on the other hand, had to consider the social context before choosing a feeding method which was fraught with societal pressure to practice mixed feeding and or longer weaning period than it was recommended and approvals by the spouse (Burkina Faso and Cameroon). The PMTCT guidelines have since been updated to support women to exclusively breast feed their infants for a longer period of time (WHO and UNICEF 2016). Husbands who were involved and or knew their wife`s HIV (Human Immunodeficiency Virus) status used their social status in the community to defend their wife`s choice of infant feeding method and protect them from criticism arising from a non-conformity to cultural norms on infant feeding (Desclaux and Alfieri 2009). A similar study conducted in Ivory Coast found that women whose partners knew their HIV prevention were more supportive and respectful of their choice to use formula milk instead of the preferred breast feeding option in the community (Traore et al. 2009). This study highlighted various ways in which husbands played an instrumental role in the care of their infants such as providing emotional support to their spouse when faced with emotional pain/regret regarding the decision not to breast feed, helping out with bottle preparations/feeding the baby and protecting them from social pressures. In addition, the husband`s acceptance and positive attitude towards the wife`s choice for replacement feeding facilitated adherence to prevention counselling received from the PMTCT programme (Traore et al. 2009). Despite positive attributes, male involvement in maternal health has been fraught with challenges.

Challenges to male involvement

Despite increased efforts to engage with men in maternal and child health, male involvement is often low (Tweheyo et al. 2010; Morfaw et al. 2013). There are differences in male and female expectations regarding the role men should play in maternal health. A study in rural Uganda observed that women`s expectations of active male involvement consisted of financial support and men accompanying them to access maternity services well as men thought of their perceived roles during the wife`s pregnancy to include an indirect role of providing financial support and ensuring the wife was well taken care of in relation to food, rest from physical work and childcare (Singh et al. 2014). Differences in

perceptions and expectations of men's roles in maternal health by women and men may contribute to misunderstandings in communities if not addressed appropriately. Challenges for male involvement in maternal health are multifaceted in nature and found at various levels; individual, interpersonal, community, health facility and national/policy levels described below.

Community factors

The studies reviewed highlighted recurrent themes on barriers regarding male involvement in maternal health such as gender stereotypes, culture, lack of knowledge, stigma and lack of time despite being conducted in different contexts and communities (Mullick et al. 2005; Davis et al. 2012; Kululanga et al. 2012; Morfaw et al. 2013; Ganle and Dery 2015; Ladur et al. 2015; Lewis et al. 2015; Mkandawire and Hendriks 2018; Sharma et al. 2018; Aliyu et al. 2019). Pregnancy and childbirth are viewed as women's roles whilst men's roles are tied to economic activities consequently limiting men's active involvement (Singh et al. 2014; Ganle and Dery 2015; Onchong'a et al. 2016). Similarly, cultural norms and beliefs that prevent husbands from witnessing delivery or attending clinics considered as women's spaces limit men's participation in maternal health (Lewis et al. 2015). Iliyasu et al. 2010 noted in Northern Nigeria, a strong community resistance for men's physical presence in the labour, for instance, men were not permitted to witness the delivery of babies due to cultural and religious reasons. A study conducted in Uganda highlighted cultural expectations of pregnant women moving back to their parents' home closer to the time of delivery in order to be taken care of by family during birth and postpartum period which limits male involvement (Kaye et al. 2014). Accompanying pregnant women to health facilities was considered as public display of affection which is viewed as culturally inappropriate in some contexts (Aborigo et al. 2018). However, in situations where pregnant women developed complications, it was acceptable for men to accompany their spouses to the health facility (Ganle and Dery 2015; Onchong'a et al. 2016). In some contexts, men who accompany pregnant women to health facilities are shunned, stigmatised and or labelled as 'weak', 'controlling', 'bewitched' and 'women's rivals' which acts as a hindrance to male involvement in maternal health (Davis et al. 2012; Singh et al. 2014; Ladur et al. 2015; Ganle et al. 2016; Aborigo et al. 2018;

Mkandawire and Hendriks 2018). Onchong`a et al. (2016, p.6) described this in an extract “the husband`s family members see you as controlling the husband and so he listens to you [wife] more”. Community attitudes of labelling men who support pregnant women may point to the fact that society is unaware of men`s roles in maternal health (Morfaw et al. 2013).

Interpersonal factors

Poor communication among couples on sexual and reproductive health was identified as a barrier to male involvement (Davis et al. 2012; Morfaw et al. 2013). Male involvement may be dependent on whether the woman wants to involve her partner or not as it is highlighted in some studies where women chose not to involve their husbands due to concerns of violence and negative experiences with their partner (Maman et al. 2011; Davis et al. 2012). Other barriers related to interpersonal factors included; fidelity and trust in a relationship in that some men only attended maternity clinics if there were suspicions of infidelity/lack of trust of female partners and men not wanting their relationship with pregnant woman known publicly (Mullick et al. 2005; Davis et al. 2012; Morfaw et al. 2013).

Individual factors

Ladur et al. (2015) identified barriers to male involvement including; lack of knowledge regarding men`s role in maternal health and men being uncomfortable attending clinics where most patients were women as illustrated in this extract,

“when sitting down on the chairs, you see women all around you and you end up shaking because you are asking yourself, are you sure of what you are doing here [antenatal care] and the things they talk about are away from what men talk about” (2015, p.8).

Work commitments may hinder some men from being attending antenatal clinics with pregnant spouses. Studies reported men reasons men`s limited involvement/absence during antenatal care/delivery clinics including the pressure of providing for their families, timing of antenatal clinics that clashed with timing for work and parental obligations in taking care of other children whilst pregnant woman went to seek health care (Davis et

al. 2012; Aborigo et al. 2018; Mkandawire and Hendriks 2018). A study conducted in Nepal reported on men working away from home which made it difficult to be physically present at health facilities with their pregnant spouses (Lewis et al. 2015).

Ganle et al. 2016 describe aspects of male involvement that were uncomfortable for some women such as men accompanying them for antenatal care/delivery and men's physical presence at antenatal clinic. The women in this study resisted men's presence at maternity clinics for varied reasons; 1) cultural perceptions that pregnancy and childcare is a woman's role and men should be breadwinners; 2) fears that men's physical presence may turn secure social/meeting spaces into insecure ones; and 3) women's desire to avoid negative stereotypes labelled on women who are accompanied to maternity clinics by the community. However, women welcomed aspects of male involvement that involved financial support and arranging for transport throughout the continuum of maternal and child healthcare. In addition, women accepted the notion of men's physical presence/escorting them to health facilities in situations when they developed a complication or medical emergency (Ganle et al. 2016).

Health facility factors

Recurrent in the literature on barriers to male involvement are long waiting times and health facilities not designed to accommodate men (Mullick et al. 2005; Tweheyo et al. 2010; Davis et al. 2012; Kululanga et al. 2012; Morfaw et al. 2013; Kaye et al. 2014; Ladur et al. 2015; Mkandawire and Hendriks 2018; Aliyu et al. 2019). Long waiting times have been highlighted as a reason for men not accompanying pregnant women to health facilities (Tweheyo et al. 2010; Ladur et al. 2015). Maternity clinics in LICs are on a first come, first serve basis with no prior appointments and understaffed which causes delays. Literature shows that the physical structure of maternity clinics are not designed to facilitate male inclusion for instance, antenatal clinics are grossly understaffed and reports of inadequate space to accommodate both men and their pregnant spouses are common which discourages men from coming to antenatal clinics (Davis et al. 2012; Kaye et al. 2014; Ganle and Dery 2015). A study conducted in a national referral hospital in Uganda highlighted negative attitudes by health workers towards men's presence at labour wards with some men being rudely chased out of the maternity clinic and or asked to wait outside

for their partners (Kaye et al. 2014). This same study observed that health workers limited men's presence in the delivery room as a precautionary measure to protect women's privacy and reduce congestion. In addition, maternity services view men as passive recipients of care and are not provided with information regarding progression of labour as illustrated in this extract:

"My wife came last night. She was told she will be operated, it is now 8 hours ago. I can't go to see her. They said men are not allowed in the labour ward. I want to see her but they have refused to let me enter. Nobody has talked to me, there is no information" (2014, p.5).

Mullick et al. 2005 reiterate the need for maternity services to view men as clients who may be experiencing emotional changes during pregnancy and delivery and need to be prepared for both processes alongside their female partners. Other barriers mentioned in the literature include; poor reception of men at maternity clinics, poor communication, men being unaware of their roles during delivery and lack of health provider confidentiality (Kaye et al. 2014; Ganle and Dery 2015; Aliyu et al. 2019).

Policy factors

At policy level, several countries in LICs lack implementation guidelines on male involvement in maternal health (Aliyu et al. 2019). In instances where guidelines exist, policies appear to discriminate or marginalise single or unaccompanied women (Kululanga et al. 2012; Mkandawire and Hendriks 2018).

Gender inequality

The active involvement of men in maternity services is not without its problems, as there are potential risks involved. Male involvement has been open to misinterpretation and perceived by some health workers/community activists as a requirement for men's physical presence at health facilities which has led to reports of unaccompanied women being denied access to health care (Kululanga et al. 2012; Contractor et al. 2016). In clinical settings, efforts to encourage male involvement must avoid unintentionally discouraging single or unaccompanied women from accessing services (Davis et al.

2012). A study conducted in Malawi noted that women report late for first antenatal care visit whilst waiting for their husbands who are not at home (Chimatiro et al. 2018). A similar study conducted in Tanzania also reported health workers turning away unaccompanied women seeking antenatal services for the first time (Peneza and Maluka 2018). During the first antenatal care visit HIV testing services are provided to couples. It is likely that some health workers could have misinterpreted this initiative to advocate for mandatory presence of men for all first-time pregnant women seeking maternity services. Male presence at health facilities may also be problematic for women who have not disclosed their HIV status/contraceptive use to male partners, which may lead to violence or divorce (Reece et al. 2010; Mohlala et al. 2011; Ladur et al. 2015). Male involvement as a strategy in maternal health does evoke strong discussions on the inherent tension and ethical implications, which seem to arise out of concerns about compromising women's autonomy/privacy and the mechanisms through which men are involved that may serve to reinforce men's dominance over women (Kiwauka 2015). This highlights the need to consider individual factors as well as gender issues whilst encouraging male involvement in maternal health.

Discussion

This review has shown that involving men in maternal health has potential benefits for the mother and her family including uptake of maternity services, nutrition and joint decision making among couples. A similar study exploring the influence of fathers regarding their partner's choice of birthplace in the United Kingdom (UK) cited the majority of fathers (82%) making joint decisions with their partner regarding place of birth (hospital birth) (Pearson and Marshall 2014). Fathers in this study gave reasons for a hospital birth such as safety and availability of facilities in case of complications (Pearson and Marshall 2014). This review observes that men would like to receive adequate information regarding labour progression and or be present during the time of delivery of baby but denied such opportunities by health workers. A similar study by Lwanga et al. (2017) reported men being denied entry into theatre and or opportunity to witness the first cry of their new-born baby. Pregnancy and childbirth are periods when men are receptive to being involved with their families and this presents a window of opportunity to engage

with men on matters regarding safe motherhood (Kaye et al. 2014). Active involvement of men in maternal health may require changing the narratives around traditional roles accrued to men and women for instance, men being viewed as passive players during pregnancy/childbirth process rather as active players/primary carer with full parental obligations (Wild 2005; Ireland et al. 2016).

Cross-cultural issues

It is interesting to see the recurrence of certain issues around male involvement in maternity care, irrespective of the geographical location of the study. We like to highlight the positive effects associated in many studies on maternity service uptake. From a very instrumental perspective it appears that men supporting their pregnant partners encourage the uptake of maternity services, especially ANC and skilled attendance at birth. In addition, male involvement does contribute to improved maternal nutrition through supporting pregnant women to adopt healthier diets and providing resources to support good nutrition at home.

Men, inequality, and humanising care

Whilst this scoping review found that involving men in maternal health has many positive attributes, findings also show that male inclusion strategies need to be mindful of already existing gender inequities that exist in society (Tokhi et al. 2018). For instance, strategies promoting faster service for couples in antenatal clinics to minimise on long waiting times may allude to a patriarchal perception regarding the importance of men's time comparative to women's time. Equally there are economic implications of both the man and woman losing time to attend maternity clinics. A greater involvement of men in maternity runs the risk of worsening gender equality rather than improving it. If maternity services improve for individual women due to male involvement this becomes self-fulfilling prophecy, i.e. the power of men makes things happen in society.

The past decade has seen more emphasis on respect for human rights in childbirth. In many high-income countries policies and guidelines stress the need for maternity care providers to respect a woman's autonomy and to empower them to make the most appropriate decisions for them. At the same time, we know that many decisions in

maternity care are not individual decisions, but joint decisions taken with the woman's partner or by the women with partners and family in mind. At the same time, there are many instances where decisions by male partners taken on behalf of pregnant women. Hence male involvement may not be applicable for all women as the needs/contexts of individual women may be different. The WHO (World Health Organization) suggests that the potential risks of involving men in maternal health can be minimised through good implementation mechanisms summarised in ten recommendations:

- i) ensure women`s autonomy in decision making;
- ii) draw on men`s positive roles in gender transformation;
- iii) ensure male involvement is in the best interests of the woman;
- iv) train health workers to promote shared decision making/respect women`s autonomy;
- v) design context specific/culturally appropriate services;
- vi) obtain women`s consent on inclusion of male partners
- vii) consider family diversity;
- viii) health facilities make provisions for male friendly services;
- ix) monitor implementation process; and
- x) link male involvement strategies to wider programmes on gender equality/equity (WHO 2015b).

Davis et al. (2012) highlight the need for male involvement strategies to place emphasis on promoting women`s choice (for instance women`s decisions on whether they want a partner involved/ specific aspects of their participation) and for health facilities to make it clear to women that they are still able to utilise maternity services without a male partner in attendance. `

Limitations of the review

This review used a narrative description of synthesised findings due to the heterogeneity in study setting, study design and outcome variables in the included studies. It enabled the description of wide range of concerns regarding male involvement in maternal health.

Conclusion

This scoping review provides insight into the current evidence on male involvement in maternal health in LMICs. Involving men in maternity services can improve health outcomes for women and infants. Health strategies aimed at educating men are relevant in equipping men with knowledge and skills that help men to be supportive of women`s wellbeing during pregnancy and childbirth. Men can serve as advocates for women and reinforce their partner`s choices in accessing skilled care and infant feeding. Further research is required to examine the effect of male involvement on women`s autonomy and to assess health education interventions aimed at mitigating harmful outcomes of involving men in maternity services.

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