Husbands in the labour ward: views and experiences of husbands in urban hospitals in southern Malawi – qualitative study.

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ABSTRACT

Background: Exploring the views and experiences of husbands who had attended the birth of their child is very vital especially in a setting where traditionally women have been accorded support by other women during labour and delivery. The insights drawn from the husbands’ views and experiences could facilitate the modelling of midwifery care from woman centred to couple centred approach. This paper explored the views and experiences of husbands who attended the birth of their child from two private hospitals in an urban setting in Malawi.

Methods: The data were collected through in-depth interviews from 20 men that consented to participate in the study from Blantyre a city in the southern part of Malawi. These men attended the birth of their child at Blantyre Adventist and Mlambe Mission Hospitals, within the past two years prior to data collection in August 2010. A semi-structure interview guide was used to collect data from the husbands with the aim of exploring their views and experiences when they attended the birth of their child.

Results: The qualitative content analysis generated four categories of husbands’ views and experiences about attending childbirth; motivation to be present during childbirth, positive experiences, negative experiences, and reflection and resolutions.

Conclusions: These results showed that with proper motivational information, enabling environment, positive midwives’ attitude and spouse willingness, it is possible to involve husbands during childbirth in Malawi. Midwives, wives and male peers are vital in the promotion of husband involvement during childbirth. In addition, husbands lack knowledge and skills to provide physical care to their labouring wives. Lack of knowledge regarding labour and delivery processes contributed to negative experiences by husbands. This was attributed to lack of preparation during antenatal period. Furthermore, husbands’ attendance at childbirth could be a motivational strategy for male involvement in family planning.

Key words: husband, childbirth, support, labour, Malawi
**Background**

Husband’s attendance at birth was still controversial in the United Kingdom even as late as the 1970s [1] and until 1947 in the United States of America when Dr. Robert Bradley advocated for continual presence of the father in labour and birth as labour coaches [2]. Later, attempts were made by advocates of natural childbirth in the United States of America to involve fathers in the process of childbirth in order to promote paternal bonding [3]. Unfortunately, such prominent advocates of natural childbirth movement as Odent did not place great emphasis on paternal participation during birth. For example, Odent discouraged the presence of men for fear of distracting women from the natural process of labour [4].

However, husband’s presence at childbirth is now almost universal in industrialised countries [5]. For instance, in the United States in the 1980s at least 80% of the fathers regardless of marital status were permitted to be present during labour and birth [6]. However, Finish hospitals allowed the fathers to be present during childbirth since 1960’s [7].

The high participation rate of husband’s presence during childbirth in the west has been influenced by a number of factors. Wertz and Wertz in Early [8] argued that, during the post-war era, a concept of ‘family togetherness’ was promoted throughout American society. The admission of the husbands into the labour room was constructed as a public statement of family togetherness, a sign of a strong middle-class marriage. Equally, husbands’ presence during childbirth was construed as a shared experience for couples [9]. Therefore, husbands’ attendance at birth was associated with a high level of quality of intimate relationship between a wife and husband in these industrialized countries. In addition, Wertz and Wertz in Early [8] stated that there existed a belief that a ‘good’ husband and a ‘good’ father would actively participate in pregnancy and childbirth. Husbands’ participation in childbirth also became a public statement of the strength of the father-infant bond [10]. As such, the emphasis on the need for women to have psychological support during labour opened up a role for men that legitimized their presence in the labour ward. From the foregoing, husbands were envisioned to offer emotional and moral support to their partners, whereas the professional staff could be left to concentrate on the physical and technical demands of the labour. Thus, non attendance of a father at childbirth could signify refusal of paternity acceptance. Seel argued that the changing family and social patterns is one of the reasons for husbands’ presence in the labour ward [11]. He argues that as people move away from the place where they were brought up and set up homes in new areas they do lose knit networks. Thus, couples with loosely knit
networks are more likely to do things together and to turn to each other for comfort and support. ‘In view of this, it is hardly surprising that women should be asking their husbands to accompany them in labour. Who else could they turn to?’[11]

However, husbands’ attendance at child birth depends on cultures and societies. For example, while a Siriono Bolivian husband is expected to be present during childbirth in order to cut the cord, a way of claiming paternity [12], a Jewish husband, according to Rabbinic law, is not allowed to touch his wife in parturition and he is not permitted to look at parts of her body which ordinarily have to be covered [13]. As such he is not allowed to be present during childbirth. Similarly, in Nepal, in the 1990s, Bajura women were left alone to give birth as no one, not even other family members were allowed to touch a woman during and for several weeks after delivery. The woman had to look after all the details of birth herself including cutting the umbilical cord [14]. The birthing woman was regarded as polluted.

Studies supporting husbands’ presence during childbirth have also documented positive childbirth outcomes such as lower perceptions of pain in the labouring mothers, fewer requests for analgesia [15,16], and improvements in the couple’s positive attitude towards the birth experience [17]. In addition, the father’s involvement in the childbirth and the opportunity to interact with the baby at the earliest stage enhanced father-baby attachment and increased the husband’s participation in early caretaking activities [18]. Pride related to fatherhood, increased respect for women [5] and improved partners’ relationship [19] are some of the positive outcomes of husband’s presence during childbirth. Furthermore, Pestvenidze & Bohrer stated that fathers can effectively provide early skin-to-skin contact to caesarean section delivered infants, contributing to the heat conservation of the babies and minimizing the likelihood of hypothermia [17]. On the other hand, some studies have documented the negative aspects of husband’s presence at childbirth. For instance, hidden fears, dissatisfaction with their own ability to support their wives [5]; more tension and excitement during delivery and inability to cope with labour [20].

Traditionally, in Malawi as in other African settings, women have been attended and supported by other women during labour and birth. The concept of husband’s attendance at labour and delivery is relatively new and in most public hospitals husbands are not normally accepted within the labour and delivery rooms. Although non Malawian studies report the
beneficial effects of husbands’ involvement in the birthing process, the results may not be applicable to Malawi as most of the studies were done in industrialized countries. Furthermore, husbands’ experiences regarding childbirth attendance have rarely been reported in countries which have similar cultural values and norms to those of Malawi. Therefore, the aim of this study was to explore the views and experiences of husbands who had attended the birth of their child. The results from this study would inform midwifery education and practice in order to provide couple centred midwifery care which is not a norm practice in Malawi. In addition, the results from this study may be used to better educate husbands on what to expect from attending a delivery. The study findings may also give health care providers further knowledge in assisting husbands who choose to be present during labour and childbirth.

**Methods**

**Design**

The design of the study was descriptive non-experimental that utilized qualitative methods. The data was collected using in-depth interviews that allowed exploration of the views and experiences of husbands towards their presences during the birth of their child. The study was part of a major project that is focusing on male involvement in maternal health care in rural and urban settings in Malawi.

**Settings**

Data for this study was collected from husbands whose wives delivered their babies at Blantyre Adventist and Mlambe Mission hospitals in Blantyre city, Malawi. The two hospitals were purposively chosen because they are among the few that do allow husbands’ presence during labour and delivery.

Blantyre Adventist Hospital is a private-for-profit facility located at the centre of Blantyre city. The American missionary doctors of the Seventh-Day Adventist Church established the hospital in 1957. It is a forty bedded hospital. It offers specialized obstetric care and is managed by an obstetrician, State Registered Nurse/Midwives (SRNMs) and Nurse/Midwifery Technicians (NMTs). Since its inception, the hospital encourages men to participate in maternal health care of their wives/partners, including attendance at delivery.
Mlambe Mission Hospital is situated 30 kilometres north of Blantyre city. It is a 254-bed facility run by the Roman Catholic Church. The hospital is one of the Christian Hospital Association of Malawi (CHAM) facilities. CHAM is an ecumenical, not for profit non-governmental umbrella organization of Christian owned health facilities. CHAM offers about 37% of health care services in Malawi [21]. Mlambe Mission Hospital signed a service agreement contract with Blantyre District Health Office to enable it provide maternal health care services to the people around its catchment area. In addition, the hospital receives obstetric referrals from six government health centres. The hospital offers antenatal care (ANC), labour and delivery and postnatal care. An obstetrician, general practitioners, clinical officers, SRNMs and NMTs, offer the maternal and child health (MCH) services. The hospital policy also encourages male involvement in maternal health care.

Sample size
Twenty interviews were sought as it was anticipated that this would be sufficient to achieve data saturation. Green & Thorogood stated that “the experience of most qualitative researchers is that in interview studies little that is ‘new’ comes out of transcripts after you have interviewed 20 or so people [22]. Corbin & Strauss defined saturation as a situation wherein no new concepts arise during successive interviews, beyond those that have already emerged [23].

Participants and recruitment
Twenty men were purposively selected to participate in this study. Purposive sampling strategy was used in which men who expressed willingness to participate in the study were selected. In addition, variation in sample with regard to educational background, age, social economic status and parity were sought. Furthermore, the participants were indigenous Malawians. Some of the participants were recruited from the health facilities as they came with their wives for other services such as postnatal check up or family planning. Other participants were recruited by snowball sampling, as the men who had been interviewed were asked to identify potential participants who could provide relevant information and had experience with male involvement in maternal health care. The participants represented urban men who were present when their wives gave birth to their child and the wives gave birth at Blantyre Adventist and Mlambe Mission hospitals.
**Ethical consideration**

Permission to conduct the study was obtained from Malawi College of Medicine Research and Ethical Committee (protocol number P.05/10/948) and the Regional Committee for Medical and Health Research Ethics in Norway. Permission to access participants was sought from the directors and chief nursing officers of Blantyre Adventist and Mlambe Mission hospitals. All participants were informed about the purpose of the study. They were also informed that their participation was voluntary and that they were free to withdraw from the interview and the study at any time without giving a reason. They were further informed that their withdrawal would not affect their entitlements to health services. A written informed consent was obtained from individual participants.

**Data collection**

Data were elicited between August 2010 and January 2011 in the city of Blantyre. A semi-structured interview guide was administered to 20 individuals that consented to participate in the study. The structured part collected participants’ demographic data and the open-ended part captured qualitative data. The semi-structured interview guide was developed basing on literature review. The questions in the interview guide were broad and open-ended and devised with the intention to enable participants to describe what they considered to be significant. The semi-structured format following an interview guide allows for both directed questions from the interviewer and freer exploration of unanticipated issues raised by the participants. The interviews were held in Chichewa and lasted between 40 to 60 minutes. The health facility management provided a private office for the interviews for the participants who opted to be interviewed at the health facility. Thus 10 men were interviewed at the health facilities, 6 at their place of work in their offices and 4 opted to be interviewed at their respective homes. All interviews were audio-recorded. Field records were taken for all participants’ responses and the hand written notes were expanded into transcripts. At the end of each interview, a summary of the record were read to the participant in order to verify the data. The participants were given a soft drink and a snack after the interview as a gesture of appreciation.

**Data analysis**

Data analysis was undertaken simultaneously with data collection in order to identify and correct errors during next interviews and to add important issues that may have come up. The
taped information was transcribed verbatim and translated from vernacular language into English. Observational field notes were incorporated into the data for analysis. Qualitative content analysis guided data analysis [24]. The transcripts were read repeatedly and words with similar meanings were grouped into categories using Nvivo 9 software. Similar categories were grouped into themes and sub-themes which are presented as results. The results contain direct quotes from participants and the narrations are reported as were spoken by participants without editing the grammar to avoid losing meaning. Expressions in vernacular language are presented in parentheses and fictitious names are used in the quotes to maintain anonymity of the participants.

Results

Demographic characteristics of the participants

The participants’ age ranged from 29 to 50 years with an average of 35 years. The parity of their wives ranged from 1 to 3 births. Educational level of the participants included form four, which 4 years of secondary education (4), professional diploma (5), bachelors degree (6), masters degree (4) and PhD (1). Their occupational background included lawyer (2), civil engineer (1), journalist (1), electrical engineer (1), motor vehicle mechanic (1), administrator (2), driver (1), accountant (3), programme coordinator (1), policeman (1), secondary school teacher (2), businessman (3) and stoke controller (1).

Thematic analysis

Husbands’ experiences and views have been presented in four categories namely; motivation to be present during childbirth, positive experiences, negative experiences and a period of reflection and resolutions.

Motivation to be present during childbirth

Several factors motivated the husbands to attend the childbirth of their children. The majority of the men indicated that the midwives informed them about the husband’s right to be present during childbirth during antenatal period. These are the husbands who escorted their wives for antenatal care. Some of the men were requested by their wives to attend the childbirth and others were encouraged by their peers. The men declared that they had to discuss with their wives about the issue and made a joint decision for the husband to attend the childbirth. It was interesting to note that some of the husbands attended the childbirth out of curiosity, they
were curious to observe the birthing process. Some of the men stated that they had heard from friends that labour is a painful experience and wanted to be their wives. Others just wanted to be there to welcome their baby. Few men stated that they just wanted to verify what they had read and heard about childbirth process by being present.

“You know what, I had not seen a woman giving birth and I was curious to see. I had seen pictures in biology books but this time I wanted to have a real experience” (35 years old lawyer).

Positive experiences

The husbands expressed that their attendance at childbirth increased their knowledge about the process of childbirth as they had witnessed one. This knowledge will enable them to offer better support to their wives in future deliveries. Most of the husbands described how they acted advocates between their wives and the health professionals. The husbands described their role as negotiating for something to be done when their wives were in so much pain; communicating the needs of the wives to the midwives when the midwives were not in the labour ward. Some of the husbands felt that they were able to offer psychological support by being there for their wives and reassuring them. The husbands expressed the joy they had to witness the birth of their child and being one of the first persons to welcome the baby into the world. Some husbands expressed that it was a feeling of reality that the baby is now here. The first time fathers stated that the birth of their baby changed their social status immediately to that of a father. The midwives started calling them ‘bambo a mwana’ meaning the father to the baby.

“I was overwhelmed with joy to see our new born baby. It was amazing that at the same time all the pain my wife was experiencing ceased” (29 years old, stoke controller)

Negative experiences

The husbands described the labour ward environment to be strange in terms of the equipment and procedures that were being carried out on their wives. This feeling made some of them to think that they should not have been there in the first place. Some of the husbands expressed that they felt that their privacy was invaded. This was in relation to the vaginal examinations and at times their wives were being exposed unnecessarily. Vaginal examinations were perceived by the husbands as an invasion to their private life (husband and wife) more
especially when the health professional was a male. This practice made the husbands feel embarrassed and ashamed. One husband said:

“The vaginal examinations that the midwives did on my wife put me off. Much as it is a procedure to monitor progress of labour, it was an invasion of our privacy.” (45year old, engineer)

Observing a labouring woman in severe pain was an experience that most men could not easily tolerate. Feelings of fear, anger and frustration set in. The husbands described that they feared for the life of their wives. They could not imagine the intensity of the labour pains. They also described that they became angry with the midwives that they were not doing much to relieve the pain their wives were suffering. Some of the men expressed being angry with themselves because they had no control over the situation. One of the participants explained that his wife had prolonged labour, she was in great pains but the doctor on call delayed to attend to her. The midwife explained to them that labour was not progressing well and that she had called a doctor on call to come and review the wife. The husband further explained that the midwife anticipated that the wife might go for caesarean section. The delay by the doctor created an intense atmosphere in the labour ward such that the husband was frustrated. He went on to explain that he could not hold his negative emotions and decided to leave the hospital and went to his office which was about a fifteen minute walk from the hospital. The husbands expressed his frustrations as follows:

“It was so frustrating to watch my wife in great pains and not being able to do anything. I was so angry that I found it difficult to control myself. I left the hospital and went to my office.” (35year old lawyer).

The husbands also feared for the lives of their wives. The fears were more related to the mode of delivery than the childbirth process itself. The husbands that were present during a normal vaginal delivery experienced negative emotions when their wives were having severe labour pains and were restless. Fear of losing the wife set in when the husbands saw the amount of blood that the wives lost during delivery. Most of the husbands stated that they were terrified with the amount of blood. The blood loss scared them. Most of them explained that they pretended to be strong for the wives but were afraid inside them. However, positive emotions were restored when the baby was born and bleeding was controlled and the mess were cleaned up.
Similarly, four husbands that attended elective caesarean section also expressed feelings of fear for the outcome of the operation (delivery). Most of them could not endure seeing a wife being cut and seeing abdominal contents. It was a frightening experience. The sight of the incision, the instruments being used on the wife and blood scared them. They feared for the life of the wives.

“I was allowed in the operating theatre to be with my wife and observe the operation. It was the first time to enter the operating theatre. I was a bit scared. They gave my wife an injection on the spine and numbed her. She was talking to me but could not feel pain. The moment they cut her abdomen I fainted. I realized after sometime that I was ushered into the recovery room by one of the midwives.” (39 year old programme coordinator).

The four husbands that attended the caesarean section of their wives declared that they would not attend future deliveries while those who attend the normal vaginal delivery indicated that they consider attending when the time comes.

In ability to offer physical support to the wife was felt by most of the husbands as a negative experience. Most of the husbands expressed that they lacked knowledge and skill to offer physical support. They stated that they did not attend childbirth classes and did not know much about physical support. Lack of knowledge frustrated most husbands as they did not understand what was going on and how to assist the woman through labour. The husbands felt that attending antenatal care with their wives did not prepare them for labour and delivery and their role in these processes. They stated that antenatal care services concentrated on the wellbeing of the mother and foetus and very little information was given to the husbands about birth preparedness and none on childbirth process and husband’s role. However, the minority of husbands stated that physical support was the responsibility of the midwives.

“I didn’t know what to do with my wife when she was restless and in pain. I felt my presence was useless as I failed to assist her when she needed help.” (40 years old accountant)

The minority of the husbands indicated that their presence in the labour ward created some tension between them and the health care providers. Some of the husbands were labelled ‘difficult’ because they kept on asking for explanation as to what was happening to their wives and even demanding for drugs when their wives were in severe pain. Other husbands
avoided confrontations with the health professionals for fear that their actions might affect negatively the care of their wives.

“I avoided to ask so many questions and to demand for care because I felt that my wife might be neglected. Although at times I felt that my wife deserved more that what she was getting in terms of medical care.” (30 years old businessman)

All the participants expressed that they were not involved in decision making about the care of their wives neither were the wives. All the decisions were made by the medical professionals and the couples were just being informed of what they were expected to do. The practice did not bother most of the husbands as they felt that they came to the hospital to seek medical care and that the medical professionals were the experts and the couple were just like passive recipients of care. However, the minority of the husbands felt that the medical professional needed to consult the couple regarding the care.

“We were not involved in any decisions that were being made regarding my wives medical care. Anyway they are the experts. I was only informed that my wife was having a complicated labour and that she had to go for caesarean section and they asked me to sign the consent form for the operation.” (29 years old driver)

**Reflection and resolution**

The period after childbirth was a phase of reflection and resolution. The husbands referred to their presence at child birth as an opportunity they had to comprehend childbirth process and iron out the misconceptions they had before. They stated that they were more knowledgeable about childbirth and appreciated the efforts of the hospitals and the midwives in encouraging husband’s attendance at childbirth. The husbands recognized the importance of husband’s presence as an opportunity for them to advocate for better care for their wives and newborn babies. One husband reported that most of his and wife’s female relations were up in the northern part of the country. It was not possible for them to come and be with the wife during labour and delivery. Thus he became the wife’s labour companion and did not regret that he did.

“This is an excellent initiative for couples who do not have other female relatives at hand to support them. My wife was not left to labour alone. At least I was there by the bedside.”(35years old lawyer).

‘I would have lost my two babies if I was not there at the hospital. When I went to check on my babies in the nursery I found my babies flabby and the incubators were
too hot. I paged for the nurses who were busy with other patients but they came in time to save my babies. ’ (47 years old journalist)

The husbands expressed that their involvement in childbirth had strengthened their relationship with their wives and children. They became very protective of their children and participated in child care. The experience increased their love and respect for the wives in particular, and women in general. Most of the husbands confirmed that the experience did not change their sex life although for some couples resumption of sexual activity took more than three months because of fear of hurting the wives, especially for those wives who had an episiotomy and caesarean section. Some of the husbands stated that having observed labour and delivery their desire to have more children diminished. Childbirth was perceived by some of the husbands as putting the life of a wife at risk of death. They made unilateral decisions not to have any more children.

“Giving birth is a life threatening experience. I don’t want her to go through that experience again. Better have one child with a mother that several without.” (39 years old, programme coordinator)

Discussion

The demographic data of the participants in this study indicate that they were not at all ‘ordinary’ Malawian men, but rather educated, professional men with a socioeconomic status that could afford to pay for private maternity care for their wives. This group of men could be likened to middle-class men in the industrialized countries. Although it is not a tradition in Malawi for husbands to attend the birth of their child, the participants demonstrated that gendered behaviour changes over time[25] and that people respond to changing contemporary norms [26]. Given the enabling environment husbands can assume the role of labour companions, a role that has been for women in Malawi. Meerabeau[9] stated that in an American society, the admission of husbands into the labour room was constructed as a public statement of family togetherness, a sign of a strong middle-class marriage. However, this belief was not established in this study.

The results of this study has illuminated on the importance of midwives, wives and male peers as motivators for husbands to be labour companions. The role of midwives as educators and
client advocates cannot be over emphasized. The midwives should take every opportunity to educate and advocate for husbands involvement in childbirth whenever possible. In addition, husband’s presence in the labour ward could compensate for midwife’s care in situations of staff shortage. Husbands could offer emotional and moral support to their wives, whereas the midwives could be left to concentrate on the physical and technical demands of the labour and delivery.

Husband and wife communication is vital for husband attendance at childbirth. In this study the couples had to discuss and make a joint decision for the husband to be present. Feyisetan [27] argued that spouse communication about reproductive health issues is greatly enhance when both spouses have similar levels of education or close to one another and that at higher levels of education and with little difference in educational attainment, partners appear to feel more comfortable discussing issues which are traditionally thought to be under the control of men. Thus, education and exposure to the western culture influence couple’s attitudes and behaviour towards increased gender equity, expressed as being together during childbirth. It should be noted that educated couples have access to mass media, internet and exposure to the outside world, factors that influence behavioural change.

The results of this study have shown that informal male peer motivation moved some husbands to attend the birth of their child. Men who have attended the birth of their child inform peers about their experiences and encourage them to participate. Thus men may be receptive to information originating from fell men. Avogo & Agadjanian [28] found that men and women’s discussions in gendered networks are significantly associated with subsequent spouse communication in family planning. They further made a supposition that social influence is directly reflected when informal social networks exchange information on childbearing.

The husbands in this study had multiple motives for attending the birth of their child. Some of the participants stated that they attended the birth of their child out of curiosity, others to welcome their baby and some to be there for the wife. Unlike in the western society where prospective fathers are expected to attend and assist their partners at the time of childbirth [29], in Malawi husband’s attendance at childbirth is not a common practice. However, husband’s attendance at childbirth depends among others on the hospital policy,
infrastructure, and midwives’ attitude towards husband’s presence, willingness of both the husbands and the expectant mother as was the case with the husbands in this study. Thus Malawian husbands are not obliged to attend the birth of their child. Nevertheless, midwives should endeavour to assist the husbands so that they should have an effective and positive experience.

Regardless of the motives to be present during childbirth, the husbands in this study assumed different roles including wife’s advocates and providers of psychological and emotional support. Being able to offer psychological and emotional support was viewed by the husbands as positive experience. Somers-Smith [30] stated that the mere presence of the partner makes birthing woman feel valued cared for and appreciated. Literature has shown that husbands can offer important psychological and emotional support to wives during labour and delivery. In turn, this can reduce pain, anxiety, and exhaustion for the woman; shorten the duration of labour, and resulting in less need for medication [15,16,30]. However, some studies have found less impact from husband’s attendance [18,31].

However, several authors have stated that husband’s assumptions of roles during labour and childbirth depend on such factors as personal characteristics, coping strategies, the perceived expectations of others, professional support, the use of medical technology, and whether or not the labouring mother has epidural analgesia/anaesthesia [1,32,33]. In this study the husbands stated that they were unable to offer physical support to their wives because they did not know how to do it. They lacked knowledge and skill. Although some of the husbands stated that provision of physical care is the responsibility of the midwife. However, husband’s presence has been shown to help compensate for care in situations where there is shortage of midwifery staff [34].

Fear for the safety of the mother and the child, anxiety and fear from observing a wife in severe pain, feelings of frustration when expected care was delayed, lack of knowledge about the process, risk of interventions such as operative delivery, were some of the negative emotions that husbands experience in this study. These negative emotions are also reported by other authors from developed countries [20,35,36]. Chalmers & Meyer [37] reported paternal fears as fear of labour, operative interventions including episiotomy, not being a good father, and loss of marital closeness, in a study conducted in South Africa. Chapman[32] made a supposition that childbirth classes could possibly assist men in preparing for the changes they
will witness in their partners during the labour experience. Knowing that these changes are
normal responses to the effects of labour might reduce men’s levels of anxiety, frustration,
and sense of helplessness.

However, it was interesting to note that almost all of the husbands reported that they hid their
negative emotions from their labouring wives. They pretended to be strong and as if all was
well. In their study on husbands’ experiences with post-perinatal loss, O’Leary & Thorwick
[38] reported that fathers are reluctant to express fears because of the need to protect their
partner. According to Courtenay [39] men often view admission of fear as a sign of
weakness, and reluctance to acknowledge fear.

Invasion of privacy in relation to vaginal examinations, especially done by a male health care
provider, was another negative experience expressed by some husbands in this study. This
finding is similar to White’s [40] study, in which the fathers described how they would have a
difficult time seeing their partner as a sexual being after witnessing the birth. White termed
the experience as “sexual scaring”. White [40] suggest that, for some men, the vision of their
partner’s body ‘being invaded, abused and traumatized’ in the labour room remained with
them for a long time and caused emotional upset. Similarly, Kitzinger [41] reported that
women who suffer traumatic birth used the language of rape victims to describe their
experiences. Longworth & Kingdon [34] postulated that male partner who may have witness
traumatic birth may be left traumatized, feeling that he colluded in the act of violence against
his partner.

Lack of knowledge and preparation for labour and delivery and role in these processes
contributed to husband’s negative experiences. In turn it created tension between husbands
and health care providers. Some of the husbands reported to be labelled ‘difficult’. Koppel &
Kaise [42] argued that hospital staff tends to underestimate and ignore the stress that fathers
are going through when their partner is involved in an emergency birth. Although, Mapp &
Hudson [43] stated that during a stressful situation everyone becomes stressed and that
include midwives and doctors, which does make communication difficult. Nevertheless, the
fathers who have been prepared well to participate productively in the labour process tend to
be more active participants, and their partners’ birth-experiences tend to be better [44]. Even
where fathers have been only minimally prepared, studies have shown a positive effect on the
general experience for both husbands and wife [19,45]. White [40] suggests that an effective
and positive birth scenario is one where the midwife, the woman and her partner work together to support each other.

The desire to have more children diminished in some of the husbands who attended the birth of their child. Similar results are reported by Carter[46] in a study done in Guatemala. However, there is need for further research to investigate the relationship of husband’s attendance at childbirth and subsequent pregnancy intentions and practices.

**Limitations of the study**
Recall bias could have been present even after restricting inclusion to husbands whose spouses last delivered 24 months prior to the study. Two years is a long period to remember much detail about one’s experiences. However, the inclusion period was extended to two years because of the scarceness of the husbands who had attended childbirth in the populace. However, the flexibility of the interview with probing helped to joggle the memory of the participants.

Another limitation is that our study population was urban; therefore our findings may not be entirely applicable to other settings in Malawi. However, we gain insights into how similar populations can be targeted to improve husband’s involvement during childbirth.

**Conclusions**
These results showed that with proper motivational information, enabling environment, positive midwives’ attitude and spouse willingness, it is possible to involve husbands during childbirth in Malawi. Midwives, wives and male peers are vital in the promotion of husband involvement during childbirth. In addition, husbands lack knowledge and skills to provide physical care to their labouring wives. Lack of knowledge regarding labour and delivery processes contributed to negative experiences by husbands. This was attributed to lack of preparation during antenatal period. Furthermore, husbands’ attendance at childbirth could be a motivational strategy for male involvement in family planning.

**Implications for midwifery practice**
From this study, it can be noted that husbands’ preparation for attendance at labour and childbirth is a critical part of a positive experience. Husbands may need education to provide effective emotional and physical support to their labouring wives. In other words, husbands
should know how to be labour companions. However, the study was conducted in private-paying hospitals where clients expected the midwives to provide emotional support along with other midwifery actions. Nevertheless, it is the duty of the midwives to discuss with the husbands on which aspects of support the husbands would be comfortable with.

Another implication of this study for midwifery practice is that orientation of the husbands to the routine care during labour and delivery is critical. Some of the participants stated that they were not prepared for the reality in the labour and delivery experience. Midwives should take time to orient the husbands on the realities and routines of labour and delivery so that the husbands should be mentally prepared. The information needs of the husbands can be met through childbirth classes and also through easy to read written materials. These adjuncts should be optimally used to help busy midwives better serve their clients. However, the midwives must take the responsibility to avoid information gaps and optimize education with their clients.

**List of abbreviations**

**Competing interests**
The authors declare that they have no competing interests.

**Authors’ contributions**
LIK conceptualized the study, collected the data, led the analysis, and wrote the text of the paper. JS, EC and AM advised on the conceptualization of the study, analysis of the data, and presentation of the results, review and edited the text. All authors read and approved the final manuscript.

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