TITLE: Male partner participation in maternity care and social support for childbearing women: A discussion paper

ABSTRACT (249 words): Male partners/fathers are key support persons for many childbearing women and their involvement in pregnancy, childbirth and the postpartum/postnatal period has beneficial effects on a wide range of outcomes related to maternal and child health and family wellbeing. Social support is implicated in the relevant causal pathway, but has received largely tangential attention in the public health literature. This discussion paper aimed to reframe men's participation in maternity care as an opportunity to enhance their readiness and ability to provide social support to women, contributing to the debate on the definition and rationale for male partner involvement, and paving the way for further empirical work.

I begin by presenting a theory of change illustrating the causal pathway leading from male partner participation, through the key intermediate step of social support, to improved health and wellbeing for women and children. I proceed by arguing that many people desire male partner participation in maternity care, however in practice this is often limited due to cultural, social and institutional barriers. I use examples from the intervention literature to demonstrate how participation in care can boost men's motivation to support women and enhance their ability to do so by increasing their knowledge and skills. Finally, I draw up general implications for further male partner involvement programmes, suggesting that in order to achieve meaningful and sustainable gains, attention to design is crucial in order to avoid reinforcing patriarchal gender norms. Programmes should be implemented alongside other efforts to improve quality and promote woman-centred care.

KEYWORDS: male partner/ paternal involvement/ male partner involvement/ men/ fathers/ male partner participation/ father participation/ public health/maternal health/ maternal and child health/ maternal and newborn health/ social support/maternity care/ maternity services/ public health programmes/ public health interventions/ gender norms/ quality of care/ woman-centred care

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INTRODUCTION

Social support is the perception or experience that one is cared for, esteemed, and part of a mutually supportive network providing instrumental, informational and emotional support (1). Social support is important during pregnancy, childbirth and the adjustment to parenthood, as these key life events may be perceived as stressful or challenging. Although in many societies older female relatives are important sources of help and advice around this time (Sears, this issue), for many women in heterosexual relationships male partners are also key supporters. This is especially relevant in societies where support from older female relatives may be less available due to demographics and/or changes associated with urbanisation (Page, this issue). Across high- (HICs) and low- and middle- income countries (LMICs), male partners provide a range of different types of support, including companionship and emotional support (2,3), looking after the newborn or other children (4), household tasks such as fetching water and cultivating the land (5), arranging transport to health facilities and contributing financially to health care and household expenditures (6).

Social support by male partners is of interest to public health due to its association, in HICs, with reduced risks of pre-term birth, low birth weight, fetal growth restriction, and infant mortality (7–9). Evidence from both HICs and LMICs also documents a protective effect against common perinatal mental health disorders in women (10,11). Key mechanisms implicated in improving maternal and child health (MCH) are thought to be alleviating women's stress (9,12), facilitating their use of skilled antenatal (ANC), postnatal (PNC) and intrapartum care (13,14), and enabling them to adopt healthy lifestyles for example by reducing cigarette smoke (15). The dynamics of social support by male partners may vary, including between HIC and LMIC, however fostering their supportive role is important across the world. This article adopts a comparative perspective across a diverse range of contexts.

In the public health literature, the term “male partner (or father/paternal) involvement” has been generally used to refer to a man's engagement, interest and participation in the process and experience of pregnancy, childbirth and new parenthood. However, definitions have varied, ranging from single indicators such as being named in the birth certificate (8) or accompanying their partner to ANC consultations (16), to indices and scales also covering men's provision of

various types of social support (17,18). In this paper I will focus on the concept of “male partner participation in maternity care” within biomedical health care systems, by which I mean partners' physical presence during ANC and PNC appointments or information/education sessions, during birth, or their engagement in targeted outreach activities organised by maternity or linked services.

I will examine male partners' provision of social support as distinct from their participation in care, and explore the relationship between the two concepts. Of course, where health services allow men to participate in care, they are more likely to do so within relationships that are already supportive. For this reason, I will give considerable space to the emerging body of intervention research indicating a causal relationship between participation in care and the provision of social support. Recent reviews have examined the determinants of paternal involvement (19), shortfalls in the design of interventions for engaging fathers (20), male partners' experiences of participation in maternity care (21,22) and their role in birth (23). Yet social support, and its distinct role on the pathway leading from male partner participation in maternity care to improved health and wellbeing, has received largely tangential attention.

The aim of this discussion paper is to reframe men's participation in maternity care as an opportunity to enhance their readiness and ability to provide social support to childbearing women. To contribute to the debate on the definition and rationale for male partner involvement, I will begin by presenting a theory of change illustrating the causal pathway that leads from male partner participation, through the key intermediate step of social support, to improved MCH and wellbeing. I will address four key topics related to this theory of change, and then discuss the general implications for further research and public health programmes aiming to achieve meaningful and sustainable improvements in health and wellbeing.

THEORY OF CHANGE

In this section, I present a theory of change linking male partner participation in maternity care with improved health, wellbeing and gender outcomes, highlighting the role of social support as a key intermediate step (Figure 1). The current level of male partner participation in maternity care and the specific types of care in which they participate within a given health system are the product of specific historical circumstances (Topic 1). In each setting, a range of “supply” factors related to the health system in question and “demand” factors related to local attitudes, norms, and preferences interact and determine the current level of male partner participation (Topic 2). The effect of these factors is mediated by social class and legal rights to leave from work,

affecting the affordability and feasibility of participation for individuals. Targeted public health interventions may be introduced to improve the demand for male partner participation or the supply of a welcoming service, both of which can alter the level of participation (Topic 3). Male partners' participation can increase their motivation to provide social support to women, the knowledge/information that enables them to provide it, and the skills/behaviours that are required (Topic 3). In turn, as described above, social support leads to improvements in health and gender-related outcomes. However, it is essential that the issues of gender and power are critically considered. The perspective and preferences of local women must be given priority in the development of public health policies, programmes and interventions seeking to facilitate or promote male partner involvement (Topic 4). Finally, this theory of change shows that the experience of involvement, of providing and receiving social support, and of better health and wellbeing can boost demand for male partner participation.

[Figure 1: Theory of change illustrating the pathways from male partner participation to improved health and gender outcomes]

TOPIC 1: To what extent do male partners currently participate in maternity care?

Levels of male partner participation in maternity care have evolved over time and vary widely across the world.

In maternity services in several HIC, recent decades have seen a gradual transition from patriarchal styles of care, classically from male obstetricians, to increasingly woman-centred services where women are repositioned as individuals with personal needs and wishes, in charge of decision-making regarding their own health care options (24). Though this shift is far from complete, one achievement has been increased opportunities for male partners' engagement. Attitudes towards male partners participating in labour, ANC and PNC started changing after World War II. In England, after hospital birth had become the norm by the end of the 1960s, male partners' presence in the birthing room became more normalised in the following decades (25). Nowadays it is common for male partners to participate in all aspects of care and be the main support person at birth (26).

In many LMIC, policies have been introduced promoting the inclusion of male partners in outpatient maternity care, particularly ANC. Rather than arising from a strong demand from communities, however, these have often been public health initiatives whose primary aim was to increase the uptake of maternity care. The 1994 International Conference for Population and

Development (ICPD) in Cairo gave considerable momentum to male involvement programmes. ICPD signalled the explicit recognition by the international public health community that engaging with male partners and addressing gender influences on health was essential to achieving and sustaining progress in reproductive health (27). In several Sub-Saharan African countries, male partner involvement also received a boost by programmes focused on preventing mother-to-child transmission of HIV (MTCT) in the light of evidence that testing both expectant parents increases adherence to preventative interventions and reduces MTCT (16,28). However, studies from several low-income countries show that less than 50% of male partners attended at least one ANC consultation (29–31). Male partner attendance at PNC and well-baby check-ups has received less attention, but is likely to be lower than for ANC (5).

During the past decade, increasing attention has been given in many LMIC to labour companionship by family, friends or doulas. Interest in this topic has grown following the WHO's inclusion of women's experiences within the concept of quality of care (32), and through a new movement to promote respectful maternity care, led by the White Ribbon Alliance (33). In addition, recent systematic reviews highlighted that continuous labour support by a companion can reduce the need for obstetric interventions, and is associated with positive birth experiences, shorter labours and reduced need for pharmacological pain relief (34,35). Thus, in LMIC, the possibility of male partners providing support in labour and childbirth is linked to the more general question of whether any support persons are allowed in facilities. In some countries, such as Kenya and Malawi, national policy has recently changed to allow male partners or other support persons to be present at birth (36,37). However, in countries such as Ethiopia and China female companions still have restricted access, limiting the provision of continuous support during labour and birth (38,39). Male partners' presence as supporters is generally less common, for example they are not allowed in parts of the Middle East (40). Attendance by male partners at facility births was around 14% in urban Nigeria and about 20% in rural Bangladesh, with the most commonly reported reason for their absence being staff refusal (41,42). Higher rates have been observed at a university hospital in Nigeria and in India (43,44). In societies where it is not the norm, the extent to which male partners participate in maternity care may reflect existing inequalities. For example, In Malawi, only private hospitals allow male partners to participate in ANC beyond the first consultation, and, sometimes, to be present for the birth (45).

I now turn to examine to what extent current levels of male partner participation in care reflect societal “demand”, and what barriers may be in place.

TOPIC 2: Is there a demand for male partner participation, and to what extent are maternity services meeting it?

Societal attitudes, gender norms, and the personal preferences of women and men are key factors in shaping the extent of men's participation in maternity services and the amount and types of support they provide. I shall refer hereafter to these factors as the “demand” for male partner participation. Equally important are health services features such as the regulatory framework, clinic infrastructure, and the attitudes and skills of health workers, all of which can enable or hinder male partner participation. I shall refer to these factors as the “supply” of opportunities for men to engage and of a welcoming environment.

Surveys show that even where the presence of the male partner at birth is not the norm, such as in Nigeria, Bangladesh, and China, many women wish that their partner could or would be with them during labour or birth (39,41,42). Studies from Ghana and Kenya have shown that women who are wealthier, employed, or with higher education are more likely to want and be allowed to have support in labour (37,46). Companionship by male partners is associated with a modern lifestyle in Tanzania and with migration to urban settings in Nepal (47,48). Women in rural Kenya reported that companions in hospital more commonly provided instrumental support, such as holding the baby while they showered, compared to emotional support (37). Regarding male partners specifically, a theme emerging from a qualitative study in Ghana is that if a man supported his wife through labour, he would 'witness her pain' and thus treat her with more respect (46). Similarly, in a survey in Nigeria, nearly 60% of women agreed that men's presence at birth would enable them to “appreciate the value of women”, whereas only 20% agreed that male partner participation could “encourage women in labour” (41).

However, there is also clear evidence that not all women want a companion and some, as reported by a qualitative study in rural Nepal, would prefer a female companion due to feeling “shy” or embarrassed (48). Another study in semi-rural Nigeria reported that about 60% of women agreed that men should accompany women to the clinic for ANC, to give birth and to PNC, but a similar proportion said they should not actually be present during birth (49). In rural Ghana, most women were content with the current separation of gender roles and with the status quo of male partners providing instrumental and financial support (50). Some wanted to

avoid being seen as dominating their husbands. Women may also not want male partners present due to intimate partner violence (IPV), which increases during pregnancy (51).

Some women's wish to maintain the current male-female separation is mirrored in studies exploring male partners' viewpoints. In South Africa, men report that their role is to provide financial, instrumental and emotional support to pregnant wives, including at times accompanying them to the clinic, but mostly not entering the consultation room (52). In Ghana and Tanzania, men report fearing ridicule by peers and the community if they get too involved in supporting their wives or attend health care appointments with her (5,53). An additional barrier is the stigmatisation of ANC due to its connection with HIV testing (29), as is the concern about having to spend money (53). On the other hand, a review of studies investigating men's role in birth from a range of mostly middle- to HIC showed that many men are willing to be present at birth, taking on an active “team-mate” or “coach” role providing practical and psychological support, as well as acting as an advocate for women (23). Others saw their role as a more passive “companion” or even “witness”.

For those male partners willing to participate in maternity care, there may be a range of “supply” barriers (54). Men who work may have difficulty attending due to clinic opening hours, or if ANC and PNC services are offered on a first-come-first-served basis rather than by appointment. This barrier would be greater for men with less control over their work, those without paid leave or those who cannot afford to miss work. Clinic infrastructure is often not couple-friendly, due to congestion and concerns for privacy in shared labour rooms. The relationship between staff and male partners is also not straightforward. Health care workers often act as gatekeepers with the power to accept or turn away would-be birth companions (55). Men report being treated rudely, ridiculed, or refused entry and forced to “stay in the sun” (56). Health workers in rural Kenya worry about being scrutinised, judged, and held accountable by companions, though many welcome their practical help (37). Remarkably similar demand and supply barriers to male partner participation have been documented in countries as diverse as Iran, Brazil and Papua New Guinea (57–59).

People's own prior experience, or that of others close to them, can affect the likelihood of male partner participation in care. Unfortunately, negative experiences are common. There is a range of evidence from LMIC and HIC that male partners who are present often feel left out during ANC, PNC and birth. Steen and colleagues characterised the experience of many men as “not-patient and not-visitor”, which situated them in an undefined space, both physically and

emotionally (21). In Malawi, men who attended their partners' births felt helpless, unprepared and unsupported, and reported tensions with health workers who perceived them as excessively demanding (45). Negative experiences have also included witnessing health workers behaving abusively towards their female partners (53). These difficult experiences during the transition to fatherhood may be linked with postnatal depression in men (22).

In sum, demand for male partner participation varies across the world and within societies based on social attitudes and men and women's individual preferences. The type of social support expected from male partners also varies. Where demand exists, this is often not matched by an adequate supply of opportunities for engagement and of a welcoming environment that meets male partners' own needs for support (20). I now explore the mechanisms through which male partner participation can affect social support provision by men, which in turn can improve health outcomes.

TOPIC 3: Through what mechanisms can male partner participation lead to increased social support for women, and hence to better health?

In this section, I present an overview of the principal mechanisms through which male partner participation plausibly leads to increased social support for childbearing women, using examples from the public health intervention literature. The same mechanisms are likely to be implicated in observational studies. These mechanisms are explored loosely drawing upon the Information, Motivation and Behaviour (IMB) model of health behaviour (60). This model suggests that interventions and programmes can achieve behaviour change by providing information to participants, increasing their motivation, and equipping them with skills.

Some public health policies and programmes have focused on *facilitating* or meeting existing demand for male partner participation in maternity care by creating a variety of new opportunities for men to engage, such as community activities, home visits, facility-based couple or group-based care and educational activities (13,14). Others including outreach or media activities are directed at *promoting* or increasing the demand for male partner involvement and participation in existing services by attempting to shift attitudes, for example by promoting more participative models of masculinity or fatherhood (61). Programmes may work both through facilitating and through promoting male partner participation.

Perhaps the most essential element in many male partner participation programmes is to increase or sustain men's motivation to support their childbearing partner. The fact itself of

being present during maternity care, or the topics that are touched upon by those delivering the programme or service, may bring up and call into question gender norms relating to what is socially and culturally appropriate for men to do. For example, a programme in Mozambique involved male-to-male community health agents called “Male Champions”, who counselled men to create new, male-friendly community norms around engagement in pregnancy (63). Participation in ANC or group education can promote male partners' familiarisation with staff, the facility, and the services offered. If the experience is positive men may attend again, be supportive of women's care-seeking, and more willingly accept and trust advice from health workers (62). Interventions may also increase men's willingness to engage in traditionally female support tasks including household chores (64).

Programmes may also increase male partners' knowledge about what support childbearing women might need and how to seek professional help, thus reinforcing their capacity to provide informational and instrumental support. Interventions often seek to redress the imbalance in knowledge resulting from men's usual exclusion from health education. For example, in Bangladesh a programme involving male partners alongside women in birth preparation counselling (65) led to better knowledge among men on birth preparation, newborn care and danger signs compared to control areas. Increased awareness may then translate into practical support. For example, group counselling in rural Vietnam led to men increasingly helping mothers to take breaks from work to breastfeed or express milk, which resulted in improved infant feeding practices (66). In Italy, increased knowledge and practical skills enabled male partners to support women to solve common breastfeeding problems leading to longer continuation of exclusive breastfeeding (67). Male partners may also be able to provide informational support to women who are facing pressure from other community members to stop exclusively breastfeeding (68).

Finally, interventions may promote greater self-efficacy in male partners, providing skills that help them give social support. For example, in Australia, a psychoeducational programme included coaching new parents on how to discuss parenting and negotiate sharing the workload of newborn care and chores (69). This programme was effective in preventing postnatal common mental disorders in mothers. Increased communication within couples may occur even when specific skills are not taught, merely through being counselled together on topics they were previously not used to discussing (62). Communication between partners during and after health consultations may lead to greater understanding and retention of health information, boosting the potential for informational support (70). Interventions may also improve overall

communication within relationships. A male partner participation project focused on family planning in Malawi, involving home visits by peer educators, facilitated a shift in gendered communication norms which enabled women to initiate conversations and men to be more receptive (71). For some couples, this promoted a sense of trust which might increase the scope for male partners to provide emotional support. Finally, where antenatal education classes are open to male partners, they may teach specific labour support skills. However, few programmes dedicated to men have been developed with this aim (72).

TOPIC 4: What are the challenges and risks involved in promoting or facilitating male partners' participation in maternity care?

The literature on interventions to facilitate or promote male partner participation in maternity care suggests that these strategies need careful planning and can entail risks. Some have been introduced without adequate consultation with the communities or women affected, failing to take local societal and cultural characteristics into account or to consider the capacity and suitability of local maternity services for integrating male partners' presence. I now examine how these design issues affect risks and programme effectiveness.

The first problem concerns putting pressure or coercing women into involving their male partner in maternity care. As detailed above, many women do not wish for their male partners to participate. Over the past decade, maternity services in some countries with high HIV prevalence (73–75) have adopted highly controversial strategies to boost male partners' participation with the main aim to carry out HIV testing. Where women are seen on a first-come-first-served basis, one such strategy is a “fast-track” service for couples so that the man can return to work. This discriminates against women attending alone, as well as reinforcing the idea that men’s work is of higher value than women's. Instances where male partner participation in the first appointment has been made compulsory have also been documented in these countries, leading to the exclusion of single women or those who can't or prefer not to involve their partner, and causing some women to skip or delay starting ANC. Pressurising women to involve their partner can also lead to other potentially harmful situations. HIV-status disclosure to male partners may increase the risk of IPV (76). Male partner participation may also disrupt women's existing support networks. For example, in northern Ghana women are concerned that the presence of male partners in maternity clinics would mean they could no longer freely socialise and discuss personal matters with other women, turning a “safe”, woman-dominated social space, into an insecure one (53).

A second, related problem, concerns the degree to which male partner participation programmes may reinforce patriarchal gender norms. At first glance it seems plausible that promoting or facilitating male partner participation in maternity services could lead to improvements in gender equality. Targeting health services and information only at women suggests that mothers alone are responsible for the everyday care of young children. The exoneration of men from these responsibilities can itself be considered to be one of the foundations of a patriarchal society. However, introducing male partner participation in the context of patriarchal societies can itself be problematic (68).

A number of programmes have targeted men as household heads, in order to integrate health-enhancing practices into their household such as optimal infant feeding, or to harness their authority as gatekeepers to allow women access to maternity services (77). For example, programmes in Eritrea and India developed a separate male cadre of community health worker to approach and educate men on maternal health, emphasising the need to respect the existing separation in gender roles (78,79). Based on a well-known framework, these programmes could be classed as *gender-neutral* or *gender-accommodating*, as they do not directly challenge the gender inequalities that may impact health, or the patriarchal norms which underpin them (80). Gender-accommodating programmes may prevent harm or encourage male partners' support in the short term where there would be limited openness to question gender norms (81). However, by working around unequal norms, programmes may inadvertently reinforce them. This is supported by observational evidence of inverse correlations between aspects of women's autonomy and male partner involvement (82).

Conversely, *gender-transformative* interventions 'actively examine and promote the transformation of harmful gender norms and seek to reduce inequalities between men and women to achieve desired outcomes' (83). However, even programmes that address aspects of inequitable relationships may inadvertently reinforce male dominance. Any programme that appeals to men's sense of responsibility towards their pregnant wife and unborn child may encourage feelings of entitlement to participate. For example, a workplace-based educational intervention for male partners in Turkey led some men to "dominate decision-making about pregnancy nutrition and infant care" (84).

Similar problems may arise within programmes that seek to improve health outcomes by promoting joint decision-making (85). In cases where a decision affecting women or children's health would have been made solely by the man prior to the intervention, joint decision-making

suggests increased equality in the relationship. However, when the decision would previously have been made by the woman alone, increased male involvement might decrease women's control over their own bodies. For example, in Malawi, after participating in a peer education programme with many merits, male partners had more favourable views of contraception but were also more likely to consider themselves the primary decision-makers in terms of their wives' contraceptive use (71). While some women might welcome sharing responsibility for such decisions, others may see their partner's involvement as eroding their autonomy in an area of life over which they previously had control (86).

The third problem concerns the fact that where health services are not women-centred, male partner participation may contribute to perpetuating, and possibly normalising, disrespectful or abusive care. Copious recent research has shown that disrespectful maternity care is prevalent throughout the world, with instances of physical and psychological abuse reported at the hands of staff (87). Where women's opinions and preferences are not generally considered important, health workers may not have the motivation, time or energy to prioritise women's needs in the presence of male partners. In general, conducting ANC or PNC consultations with couples rather than just women requires specific skills which health workers may not possess. In particular, in societies where relationships are characterised by a male-female dynamic of domination and subordination, couple consultations may make women reluctant to express themselves, increasing their risk of becoming passive participants in the care process (88). The presence of male partners at the time of birth may also be problematic. Although the presence of a support person is associated with a lower likelihood of staff mistreating birthing women (89,90), men may sometimes side with staff and compel women to obey instructions, or discourage them from listening to their own instincts in labour. For example, providers may call on labour companions to help them deal with “uncooperative” women (37), or male partners may pride themselves on their ability to stop their wives from pushing at the “wrong” time (91).

Third, if programmes are not carefully planned, their effectiveness in enhancing social support by men may be compromised. Social support itself is only meaningful to the extent that it meets women's wishes and needs. Moreover, there is compelling evidence from two systematic reviews that, compared to gender-accommodating programmes, those that combine health and gender goals result in greater and longer-lasting effects (81,83). In sum, these problems point to the need for carefully planning male partner participation interventions.

GENERAL DISCUSSION AND RECOMMENDATIONS

This discussion paper presented a theory of change linking male partner involvement with improved health and gender outcomes highlighting the key role of social support, and, within this framework, addressed key topics related to male partners' supportive role as prompted or enabled by their participation in maternity care. Male partner participation in maternity care varies widely across the world, from near-universal to rare, reflecting existing “demand” for participation and “supply”-side barriers. Key oversights include the failure to offer a welcoming service environment and missed opportunities for engagement. Within communities, I found evidence of concordance between men and women's attitudes, but commonly services did not adequately meet existing demand. Male partners' participation, and provision of social support, can be promoted through increasing their motivation and furnishing them with the information and skills that enable them to do so. However, design issues may compromise programmes' ability to increase social support by men in a sustainable way, as well as put women at risk. These include coercive approaches, the failure to address unequal gender roles, and the perpetuation of disrespectful and abusive care.

While I have not exhaustively covered the various strands of relevant literature, I have sought to summarise across a wide range of health literatures which are sometimes produced without mutual awareness such as those focused on “male partners” versus “fathers”, or LMICs versus HICs. The theory of change presented above seeks to graphically summarise the state of the knowledge and the rationale for promoting male partner participation in maternity care. I will now highlight the main cross-cutting issues and implications for future programmes and research.

First, the literature suggests that many couples around the world are keen for men to be involved and participate in maternity care as supportive partners, and that the problem of male partners not being prepared, welcomed or supported is ubiquitous, potentially causing anxiety, frustration or even trauma (22). Men's own need for emotional, instrumental and informational support must be explicitly addressed by programmes to enable them to fulfil their supportive functions towards women (20). For example, those providing labour and birth support should be offered dedicated training and mentorship, and provided with essential facilities so that they can eat, rest, and shower (92). Health providers should be trained in interpersonal skills to work with men or couples and develop relevant content (93).

Second, programmes need to explicitly address the issue of gender at the design, monitoring and evaluation stages. Public health programmes and interventions must avoid top-down, patronising approaches. They should conduct a full baseline assessment of cultural and social factors relevant to the

setting, including considering how gender might intersect with other vulnerabilities such as race, poverty, class and disability (8,94). In this regard, programmes initiated within a health systems framework might benefit from considering multi-disciplinary perspectives (REF HERE TO ISSUE INTRO). Providers' levels of gender competence should be specifically addressed (95). Training should also include simple practical strategies for safely involving male partners such as speaking to women separately first (88).

Finally, both the failure to integrate men when women want their support, and the imposition of men's presence when they don't are symptoms of poor-quality care. Care that is not women-centred, but rather "institution-centred", risks failing to meet both women and mens' needs (96). Across the world, women should be allowed more say on how maternity services are organised and what they perceive to constitute quality care. The participation of supportive male partners should be facilitated or promoted alongside efforts to improve other aspects of quality.

Further qualitative research should explore the perspectives of men, women and health providers, particularly in relation to their expectations and wishes for male partner participation and support. New programmes and interventions must be carefully designed and clearly articulate the theoretical framework underpinning them and the mechanisms through which they are expected to achieve their aims (97). As well as measuring behaviours such as couple communication, joint decision-making, and the provision of support, programmes should monitor and report on strong measures of gender attitudes to capture the nuances of couple relationship dynamics (13,94). This empirical work would further our understanding of the mechanisms that link male participation with social support and permit the refinement of our theory of change and other relevant models such as the IMB model. Finally, I encourage the development of valid and feasible measures of male partner participation and involvement.

CONCLUSION

Male partners are important providers of social support to childbearing women, and their involvement in pregnancy, birth and the postpartum period can positively affect family health and wellbeing. I presented a theory of change which illustrates how social support is a key element in the causal pathway. Participation in maternity care can enhance male partners' ability to support women by increasing their motivation, knowledge and skills. However, men's engagement with maternity services and preparation to fulfil their supportive role is often limited due to a range of cultural, social, and institutional barriers. Public health programmes seeking to increase male partner involvement must promote more equitable gender norms and take place in the context of broader efforts to improve quality of care, in order to achieve meaningful and sustainable gains in social support and health.

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