Maternal, Newborn And Child Health

Although ways in which men can help alter gender-based healthcare inequities has drawn increased interest over the years, relatively little research, programme or policy efforts have focused on the role of men in maternal, newborn, and child health (MNCH)—including as fathers, husbands, and service providers (Carter and Speizer, 2005).

The period surrounding pregnancy, however, is now increasingly seen as an opportune time to engage and educate men about health in general and the well-being of their families in particular. **Research has found that expectant and new fathers are often particularly receptive to information that will ensure the survival and health of their babies.** This corresponds to increased interest in acquiring information about their health and how risk-taking behaviours affect the welfare of others (Burgess, 2007).

More importantly, male involvement during the prenatal, newborn and early childhood period can lead to positive outcomes for fathers, mothers and children, including increasing the likelihood that the father will continue to participate in care giving throughout his children's lives (Burgess, 2007).

BOX 1 **MATERNAL, NEWBORN AND CHILD HEALTH: AN INTERNATIONAL PERSPECTIVE**

Maternal, newborn and child health refers to the health of women during pregnancy, childbirth and the postpartum period and the health of newborns and children under the age of five. Millennium Development Goal Five (MDG 5), which seeks to reduce maternal mortality by three-quarters by 2015, has shown the least progress of all the MDGs (Rosenfield et al., 2006).

It is estimated that over 529,000 women die annually from complications during pregnancy, childbirth, and the postpartum period while an additional 20 million women endure lifelong disabilities such as pelvic pain, incontinence, obstetric fistula, and infertility. Unsafe abortions account for approximately 13 per cent of all maternal deaths or about 68,000 per year (UN Millennium Project 2006). Nearly all of these deaths and disabilities occur in developing countries (UNFPA, 2005).

The fourth Millennium Development Goal (MDG 4) seeks to reduce the under-five mortality rate by two thirds by 2015. The leading causes of infant and child deaths—pneumonia, diarrhoea, malaria and measles—are easily prevented through simple improvements in basic health services and interventions, such as oral rehydration therapy, insecticide-treated mosquito nets and vaccination. Disparities in infant and child health outcomes across regions are significant—a child born in a developing country is over 13 times more likely to die within the first five years of life than a child born in an industrialized country. Sub-Saharan Africa accounts for about half of the deaths of children under the age of five in the developing world. (United Nations, 2008)

Persuading men to become more involved in MNCH can also redress broader gender inequities. Women often shoulder the burden of caring for children and domestic work. This is one reason why they both earn less and tend to be employed as part-time or informal labourers. It follows then that the more men are involved with childcare the more they will help to diminish these inequalities—both in the workplace and at home (Burgess, 2007).

Gender norms and inequities play a major role in maternal, newborn and child death and disability. In many countries the low social status of women means many have hard time gaining access to the information and services necessary for a healthy pregnancy, birth and postpartum period. In many settings it is usually men who control the household income and who hold the decision making power in matters which can affect maternal health—whether it be with respect to access to social services or reproductive and contraceptive choices (IGWG, 2005; Orji et al., 2007). More critically, it is also often men who make the decision as to whether a woman can seek help if she develops complications during pregnancy, childbirth or soon after. Although men are often the principal decision-makers, many are unaware of the possible complications that a woman may experience during pregnancy and the post-partum period and may be unwilling or unable to talk to her about it.

Even where men do not directly obstruct a woman's access to services, the nature and extent of their participation throughout this period can influence the health experiences and outcomes of women in addition to those of newborns and children. For example, research has found that a father's presence (or, indeed, that of another close friend or relative) at the birth can help make labour and delivery a more positive experience for the mother (Burgess, 2008). Likewise, a mother's decision to initiate and sustain breastfeeding, a practice which has been linked to positive newborn and child health outcomes, can be influenced by the father's own attitudes about nursing (Burgess, 2008). **At the same time, it is important to recognize that male involvement in and of itself does not necessarily ensure more favourable MNCH outcomes—especially, if male behaviour is domineering and controlling (Carter and Speizer, 2005; Mullany et al., 2005).**

In many settings, men are still largely marginalized from MNCH-related services and activities. This can often be attributed to discriminatory attitudes among health providers or to men's lack of knowledge about MNCH and the important role they can play. Other reasons for their marginalization are often related to larger social and economic factors such as the inability of many men to take time off from work to attend pre-natal sessions or newborn check-ups (Carter and Speizer, 2005). Barriers to take time off can be financial—particularly for those men who are paid on an hourly basis—or structural as in the case of those companies/employers who do not recognize that participating in pre-natal and newborn check-ups is a critical aspect of fathering. Moreover, and as discussed in the introduction, men are often less likely to seek health and social services owing to ideals of masculinity which dictate that seeking help is a sign of weakness.

If men do seek services, it is often because of concerns relating to sexual health—e.g. treatment for STIs or condoms. Health services, in turn, often do not take advantage of this opportunity to engage men in discussions about reproductive health or MNCH. Indeed, reproductive health and MNCH services are often female-oriented and service providers may be unaware of the importance of engaging men and/or of how to do so. Efforts may also be complicated by the fact that women may not feel comfortable in the presence of unrelated men if facilities have not been designed to accommodate both. As a result, clinic staff may be less welcoming to male clients.

There is little comparative data about the current nature and extent of men's involvement during antenatal, birth, and postnatal care services, nor with respect to societal expectations about men's involvement. Existing evidence suggests, however, that men support MNCH in varying degrees—ranging from accompanying women to health care visits to helping with household chores. A study of fathers in El Salvador found that 90 per cent had participated in at least one prenatal care visit, delivery, or a postpartum well-baby care visit (Carter and Speizer, 2005). Similarly, a study undertaken in four countries in Central America found that 96 per cent of male respondents agreed that it is important to support partners through the pregnancy and birth (Hegg et al., 2005). In Nepal, 57 per cent of women attending antenatal care at a large urban hospital reported that their husbands helped them to reduce their workload (in Mullany et al., 2005). In England, it is estimated that 86-98 per cent of fathers are present at the birth of their children (Kiernan & Smith, 2003; National Health Service, 2005 in Burgess, 2008). Moreover, research has also found that women prefer that men become more involved with maternal health (Mullany et al., 2005).

Research has also found that the reasons men may not be involved in MNCH are more often related to external or structural factors such as work demands, hospital regulations, and health provider attitudes than to men's perceptions of gender roles or negative attitudes about MNCH (Carter, 2002; Carter and Speizer, 2005). Moreover, a

variety of factors influence the experience of fatherhood and to what extent a man will become involved. These include the relationship with the mother and their age (see Box 2 Young Fathers and MNCH, for example) as well as cultural and social norms related to men and care-giving.

Finally, it is noteworthy that men's engagement in MNCH extends beyond fathers but also to brothers, in-laws, other male relatives, as well as male religious and community leaders. In some settings, male leaders can play a key role in discouraging child marriage, early childbirth and other local practices and traditions that may affect MNCH outcomes, including female genital mutilation/cutting. Because there is so little opposition with respect to discussions relating to motherhood and children, mobilizing men for MNCH can provide an entry-point for engaging them on other issues such as GBV and the education of girls (Kamal, 2002).

BOX 2 YOUNG FATHERS AND MATERNAL, NEWBORN AND CHILD HEALTH

Younger fathers often have a harder time getting involved with MNCH than older fathers. Families, service providers and other gatekeepers may not believe that young fathers are able or willing to care for their children.

Because many young fathers lack the necessary social and financial resources to take on the responsibility of childcare, MNCH services and programmes can be crucial. They can affirm a young man's identity as a father; encourage his participation in MNCH; provide information and counselling with regards to parenting skills and child development and address his anxieties and concerns regarding childbirth and parenting.

Many young fathers may also face rejection from their partner's family and may believe they are unwelcome and inadequate as parents. Young fathers who are not living with the mother of their children may also need specific information about issues such as birth registration and child support.

When possible, MNCH services and programmes should also seek to engage the young father's wider family (his own family and that of his partner) as well as his peers. Family and peers can play a key role in either facilitating or obstructing a young father's engagement with his child or children.

BOX 3 KEY ROLES MEN CAN PLAY IN MATERNAL, NEWBORN AND CHILD HEALTH

Plan their families: Men can discuss with their partners when and how many children to have. It is important that decisions are arrived at jointly and that men do not insist on more children than partners want.

Support contraceptive use: Men should also discuss contraceptive choices and preferences with partners and accompany them to see a family planning counsellor or attend health worker visits. The goal is to decide together which contraceptive method (or combination of methods) best meets the couple's needs.

Help pregnant women stay healthy: When his partner becomes pregnant, a man can encourage her to obtain proper antenatal care and offer to accompany her during clinic visits, provide transportation or funds to help pay for expenses. He can also take the time to learn to recognize the symptoms of pregnancy complications and make sure that his partner eats nutritious food, especially food high in iron and fortified with vitamin A.

Continue to be a respectful sexual partner: It is important that men (indeed, couples) have accurate information about sex during the different stages of pregnancy and postpartum. Although there are many preconceived notions and myths about sex during pregnancy, generally-speaking it is safe for a woman so long as her pregnancy is normal or low-risk. As at anytime in the relationship, however, men should respect whether or not his partner wants to engage in intimate relations. In some countries, the widespread belief that women cannot have sex during pregnancy and/or soon after often serves as a "justification" for a partner to engage in extramarital relationships.

Addressing the norms and myths that support these perceptions and types of behaviours is an important part of MNCH programming. Moreover, men need to be reminded that STIs can be harmful to mother and baby and can trigger premature labour and cause other serious complications. If there is any possibility that a man is infected he should use a condom.

Arrange for skilled care during delivery: Men can help to ensure that a trained attendant will be present during the birth by arranging ahead of time for transportation to a clinic or health post, identifying a blood donor in the case of an emergency, and arranging care for those children who will be left behind. For home births, men can help purchase necessary supplies and arrange for transportation in the case of an emergency.

Avoid delays in seeking care: Men can play a crucial role assuring that women receive prompt care by learning to recognize the signs of an imminent delivery and of potential complications.

Provide support during the birth: Another way men can help is by learning about breathing techniques and movements that can help alleviate the pain of delivery. Male partners can also make sure that their partner has enough food and drink and is adequately distracted between contractions.

He can also advocate on behalf of his partner to healthcare providers. The emotional support that a man can provide during birth is valuable and can help to transform the pain of birth into more positive experience for the woman.

Provide support after the baby is born: During the postpartum period men can provide extra support with housework and childcare. They can be directly involved in newborn care by changing diapers, bathing, putting them to sleep, burping, and even feeding when appropriate.

This early contact strengthens the father-child bond as well. They can learn how to spot potential postpartum complications and to seek help when they occur. Male partners can also help to ensure that the new mother is well nourished and can encourage her to breastfeed. Finally, men can begin using contraception, either as a temporary measure to make sure that subsequent births are adequately spaced or if no more children are desired, undergo a vasectomy.

Be responsible fathers: Men promote their children's health by ensuring that they are immunized, are well nourished, have access to clean drinking water and are well-cared for if they fall ill.

As role models, fathers can support their daughters' education, teach their sons to respect women and to treat them as equals, and encourage them to play an active role both within and outside the family.

SOURCE: DRENNAN, 1998

BOX 4 MEN AS ALLIES IN THE PREVENTION AND TREATMENT OF OBSTETRIC FISTULA

Obstetric fistula is a preventable childbirth injury that occurs when a woman endures obstructed labour for an extended period without a Caesarean or any other type of medical intervention to relieve it.

It is estimated that at least two million girls and women living in Africa, Asia and the Middle East are suffering with obstetric fistula, and that an additional 50,000 to 100,000 girls and women develop obstetric fistula each year (UNFPA, n.d.).

During obstructed labour, the soft tissues of the pelvis are compressed between the descending baby's head and the mother's pelvic bone. The lack of blood flow causes tissue to die, creating a hole between the mother's vagina and bladder (known as a vesico-vaginal fistula), or between the vagina and rectum (a rectovaginal fistula) or both. The end result is that she is left leaking of urine or faeces or both.

Girls and young women between the ages of 10 to 15 years are especially vulnerable to obstetric fistula because their pelvic bones are not yet sufficiently developed to withstand childbearing and delivery. Fistula can generally be repaired through a specialized surgery; however, most women with the condition do not know that the treatment exists or cannot afford it. Moreover, not all doctors can repair fistula—it requires training and in many poorer countries only a few hospitals offer the surgery.

In addition to physical health consequences, a girl or woman with fistula may also suffer social stigmatization. Men—as husbands, fathers, and leaders—can help prevent and treat obstetric fistula by promoting female education and empowerment, advocating against child marriage and other harmful practices, and access to family planning and appropriate and timely obstetric care.

SOURCE: WWW.ENDFISTULA.ORG

PROGRAMMING FOR ENGAGING MEN AND BOYS IN MNCH

Engaging men in MNCH requires a combination of services-based, education, and community outreach and advocacy efforts. On a services level, engaging men may involve training staff and adapting spaces and services so that they are more welcoming for men. On a community level, efforts should aim to change attitudes regarding men's involvement in MNCH, persuade decision-makers and local leaders to get involved and raise general awareness of couple and gender-friendly MNCH services that exist. Finally—as will also be discussed in this section—it is necessary to advocate for changes in the structures and policies (e.g. paternal leave) that often limit men's opportunities to participate in MNCH.

GROUP EDUCATION

In many countries, caring for children is viewed as an exclusively female domain and girls and women often practice and learn care-giving from an early age (e.g. caring for siblings, playing with dolls). Boys and men, on the other hand, most often learn that they need the skills necessary to become a good provider, but not necessarily caregivers. **Men and boys need an opportunity to develop the necessary confidence and skills to care for children.**

Because the concerns of a father may differ from that of the mother, programmers need to recognize differences and address needs separately. This can be accomplished in a variety of ways: including through couple's sessions where men and women divide for a short period to discuss their concerns separately (Fisher, 2007). It is best to advertise these as services for both "mothers and fathers" and to avoid using the term "parent" which is commonly understood by both men and women to mean mothers only. Also, it is recommended to avoid using such terms as "group", "education" or "class": Advertising interventions as "how to" information sessions focusing on the baby is far more likely to attract fathers (Fisher, 2007).

Specific content will be discussed in more detail in the following section on services. Case Studies 1 and 2 present examples of education efforts undertaken outside the health services context. The following section discusses services- based strategies designed to serve as an entry-point to educate expectant fathers on MNCH issues.

CASE STUDY 1

BOOT CAMP FOR DADS

(PROGRAMME TYPE: GENDER TRANSFORMATIVE)

In the United States, a peer-led programme model called Boot Camp for New Dads invites small groups of expectant fathers to spend an afternoon with two or three "mentor fathers" who bring their babies with them.

A trained facilitator is present, but other than that, there is no curriculum or fixed list of issues to cover. Rather, the expectant fathers are simply given the opportunity to discuss their expectations and concerns with other fathers, and to witness practical baby care in action—changing nappies (diapers), cuddling, massaging, etc.

The role of the facilitator is also to identify those expectant fathers who could serve as mentor fathers to future groups. Proven successful in a wide variety of communities and settings, the programme works with and through maternity services, child health clinics, religious institutions, and in military bases. Over 150,000 men have participated to date and the programme has now expanded internationally to include Italy and Japan.

FOR MORE INFORMATION: WWW.BOOTCAMPFORNEWDADS.ORG

BOOT CAMP FOR DADS

CASE STUDY 2

FATHERS' CLUBS IN RURAL HAITI