

RESEARCH ARTICLE

Husband/partner involvement as a companion of choice during labor and childbirth in Nigeria: A qualitative study

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Abstract

Having a husband/partner as a companion of choice (COC) throughout labor and delivery is an intervention for improving women's birth experience and outcomes. Despite these advantages, experiences of husband/partner involvement as a COC in Nigeria remain poorly documented. We conducted a qualitative study to explore the experiences of men and women in a union who had recently experienced husbands/partners involvement as a COC during labor and childbirth. A total of 31 in-depth interviews were conducted in two states in Nigeria. All interviews were tape-recorded, transcribed verbatim, and thematically analyzed using the hybrid approach with the aid of NVivo, a qualitative data analysis software. Three broad themes emerged from the narratives: (i) the process and practice of male involvement as a COC, (ii) the benefits of male involvement as a COC, and (iii) the disadvantages. The process and practice included male COC participation as either an unwritten rule or optional, no prior preparation, insistence on presence, voluntary participation/joint choice, primarily a role of emotional support, and motives beyond promoting a positive birth experience. The benefits revolved around compassion and empathy, postpartum support, curbing intimate partner violence and son preference, facilitated/smooth delivery, and acceptance of family planning. Participants expressed disadvantages such as the potential to induce intimate partner violence and postpartum sexual strain. The findings provide valuable insights for policy development in Nigeria to harness the benefits of male involvement as COC during labor and childbirth and minimize the disadvantages.

Keywords: Labor; Childbirth; Companion of choice; Male involvement; Nigeria

1. Introduction

Maternal and neonatal mortality rates in Nigeria are among the highest in the world. In 2023, Nigeria accounted for approximately 28.7% of global maternal deaths and contributed 11.9% of neonatal deaths in 2022 (The United Nations Inter-agency Group for Child Mortality Estimation, 2023; World Health Organization, 2025). The World Health Organization (WHO) recommends interventions to reduce these deaths and to ensure pregnancy and childbirth are positive experiences for women. One of the interventions is a companion of choice (COC) throughout labor and delivery (World Health Organization, 2018). A COC is an individual chosen by a woman to provide practical, emotional, and spiritual support throughout labor and childbirth (World Health Organization, 2018). Existing evidence suggests that the presence of a COC during labor and childbirth has positive effects on perinatal outcomes, women's satisfaction with the birth experience and outcome, rates of spontaneous vaginal birth, early initiation of breastfeeding, reductions in caesarean sections, and decreased need for instrumental delivery, among others (Bohren *et al.*, 2017; Morhason-Bello *et al.*, 2009; World Health Organization, 2020). In particular, a partner/husband's involvement as a COC throughout labor and childbirth has been reported to enhance women's birth experiences and positively affect men as individuals (Bohren *et al.*, 2019).

Despite its benefits, implementation remains slow globally, with coverage varying widely across different settings (Bohren *et al.*, 2023). Many countries, particularly in Africa and the Eastern Mediterranean, have no policies on companionship for women during labor and childbirth (World Health Organization, 2020). According to some evidence in the literature, implementing COC during labor and childbirth as a policy in developing countries faces challenges. Studies in Thailand, Burkina Faso, Nigeria, and other developing countries identify challenges such as limited space, high patient volumes, lack of privacy in labor wards, hospital policies, and cultural norms (Kabakian-Khasholian & Portela, 2017; Rungreangkulkij *et al.*, 2022; Senanayake *et al.*, 2017; Vehviläinen-Julkunen & Emelonye, 2014; Yaya Bocoum *et al.*, 2023). Healthcare providers' concerns about interference with procedures, as well as a lack of awareness of the benefits, further impede implementation (Bangal *et al.*, 2018). Despite these challenges, the World Health Organization emphasizes that the presence of a COC during labor and childbirth is a woman's right and a fundamental component of respectful maternity care that can significantly enhance the birth experience when effectively implemented (World Health Organization, 2020).

Nigeria has no policy on the implementation of COC in hospitals, but it is a common practice in public and private health facilities. However, the way it is practiced and the experiences of male COCs during labor and childbirth are not adequately documented. Historically, in Nigeria and many African countries, childbirth was seen as a female affair, with men largely excluded (Aládésanmí & Ògúnjnmí, 2019; Mbadugha *et al.*, 2019). Traditional practices barred men from entering the labor and birth rooms; they were only informed after the birth had taken place. In the colonial era, when hospitals were introduced, and in the post-colonial era, male exclusion continued, as health providers often prevented men from entering the labor room.

However, in the late 20th century, a shift in policies on reproductive health in Nigeria, owing to global initiatives, encouraged male involvement in pregnancy and childbirth, albeit to a limited extent (Sharma *et al.*, 2019). With education and community-based interventions in Nigeria, there has been a gradual increase in awareness and male involvement as COC (Olayemi *et al.*, 2009). On the contrary, cultural shifts that took place in the 1950s and 1960s led to the near-universal practice of partner involvement during labor and childbirth in Europe and North America (King, 2017; Schmitt *et al.*, 2022).

Previous studies on COC in Nigeria centered around women's preferred COC, effects, and the factors associated with their preferences (Adeyemi *et al.*, 2018; Ibitoye & Phetlhu, 2018; Morhason-Bello *et al.*, 2009); motivations of men who accompany their wives/partners as COC (Umeora *et al.*, 2011); and women's attitude toward COC (Asogwa *et al.*, 2019; Morhason-Bello *et al.*, 2008). Other studies focused on women's expectations of male COCs and their level of participation (Adeniran *et al.*, 2015; Olayemi *et al.*, 2009). It is important to note that these studies were facility-based and mainly quantitative. For a more in-depth understanding of how people experience and view male involvement as COC, qualitative approaches are most appropriate. Qualitative studies on this subject are mainly conducted in more developed regions with contexts that differ from Nigeria. Bohren *et al.* (2019) conducted a systematic review of qualitative studies on perceptions and experiences of labor companionship across the globe, including male partners, but most of the studies were conducted in high-income countries and were limited to men who had been companions during labor and childbirth.

We conducted a qualitative study to examine male involvement as COC during labor and childbirth. The perspectives of women and men who had experienced husband/partner involvement as COC in a recent birth

were explored to elucidate their lived experiences of the practice. Anchored in an integrated conceptual framework informed by the socioecological model and a gender transformative perspective, we analyzed the elicited experiences. We believe that this research will provide valuable insights for interventions and guide the implementation of this life-saving practice in Nigeria to achieve a more positive intrapartum experience and birth outcomes.

The socioecological model conceptualizes health behaviors and outcomes as the product of interactions across multiple interrelated levels of influence, typically including the individual, interpersonal, institutional, community, and policy or structural levels (Bronfenbrenner, 1977). In the context of husband/partner involvement as a COC during labor and childbirth, the socioecological model is particularly useful for understanding how experiences of men and women are shaped not only by personal choices but also by relational factors, cultural norms, health system organization, providers' attitudes, facility infrastructure, and national policies. On the other hand, the gender transformative perspective emphasizes interventions and social processes that challenge, shift, and transform harmful gender norms, power relations, and inequalities, rather than merely accommodating existing gender roles and norms (MacArthur *et al.*, 2022). In reproductive health research, this perspective recognizes that male involvement can either reinforce male dominance or promote more equitable unions, depending on how the involvement is structured and supported (Lamsal *et al.*, 2024). Involvement of husband/partner as a COC has the potential to foster empathy, shared responsibility, respect for women's bodily labor, and more equitable family decision-making.

2. Data and methods

2.1. Study design

This descriptive phenomenological study explored perceptions of the practice and experience of husbands/partners as COC during labor and childbirth. The phenomenological design was suitable because the study sought to document the perceptions of people based on their experiences with the practice of husband/partner involvement as a COC during labor and childbirth (Groenewald, 2004).

2.2. Study setting

This study was part of a large qualitative research project conducted with in-depth interviews (IDI) and focus group discussions in 2022–2023 in two states in southern Nigeria, namely Edo and Ekiti. The general objective of the larger

research project was to explore the perceptions of men, women, health providers, and policymakers regarding the involvement of men as a COC during labor and childbirth in Nigeria. Specifically, the large study aimed to: (i) investigate the perceptions of women, men, and health providers about male involvement as a COC during labor and childbirth; (ii) examine the potential constraints of implementing male involvement as a COC in Nigeria; and (iii) propose interventions to address the constraints to the implementation of male involvement as a COC during labor and childbirth in Nigeria. This study focuses on the primary objective of the larger study, presenting only the perceptions of women and men who had experience with a husband/partner as a COC.

Nigeria operates a three-tier health system, with primary healthcare at the base and referral hospitals at the secondary and tertiary levels. Basic obstetric care is offered at the primary healthcare level, whereas referral hospitals offer comprehensive care. There are many privately owned hospitals in the country. Administratively, Nigeria has 36 states and a federal capital territory, Abuja. The states and federal capital territory are further grouped into six geopolitical zones, also called regions: North-central, Northeast, Northwest, Southeast, South-south, and Southwest. Ekiti and Edo states are located in the Southwest and South-south regions, respectively. Available evidence on neonatal mortality rates (NMRs) shows that the South-south and Southwest regions have the highest NMRs in the southern regions, and Ekiti and Edo are among the states with an NMR of over 50 per 1,000 live births in the two regions, above the national average of 34 per 1,000 live births. Additionally, the utilization of health facilities for delivery care in the two states is higher than the national average of 49%, with 87.5% in Edo and 77.8% in Ekiti (National Bureau of Statistics & United Nations Children's Fund, 2022).

2.3. Study population and recruitment

The study participants were women and men in a union (women = 16; men = 15). The participants were selected from diverse age groups and educational backgrounds, allowing for a wide range of perspectives across socioeconomic and professional backgrounds. Eligible participants were recruited by field supervisors, with the help of gatekeepers, from September 16, 2022, to November 19, 2022. The inclusion criteria were being currently in a union, having had a recent birth, and having experienced a husband/partner as a COC during labor and childbirth in the recent birth. The description of each interviewee's characteristics and the archival number by study location is presented in Table 1.

Table 1. Distribution of in-depth interviews by location

Location	Age	Sex	Education	Marital status	Co-residence with spouse	Occupation	Religion	Number of children	Completed childbearing	Archival number
Ekiti	25	Female	College/university	Married	Yes	Civil servant	Christianity	3	Yes	COC_EK_IDI_W01
	31	Female	College/university	Married	Yes	Hospital attendant	Christianity	1	No	COC_EK_IDI_W02
	23	Female	College/university	Married	Yes	Civil servant	Christianity	1	No	COC_EK_IDI_W03
	39	Female	College/university	Married	Yes	Teaching	Christianity	4	Yes	COC_EK_IDI_W04
	36	Female	College/university	Married	Yes	Trader	Christianity	3	Yes	COC_EK_IDI_W05
	28	Female	College/university	Married	Yes	Teacher	Christianity	3	Yes	COC_EK_IDI_W06
	40	Male	College/university	Married	Yes	Civil servant	Christianity	1	No	COC_EK_IDI_M01
	31	Male	College/university	Married	Yes	Artisan	Christianity	1	No	COC_EK_IDI_M02
	28	Male	College/university	Married	Yes	Businessman	Christianity	1	No	COC_EK_IDI_M03
	41	Male	College/university	Married	Yes	Civil servant	Christianity	4	Yes	COC_EK_IDI_M04
Edo	42	Male	National diploma	Married	Yes	Self-employed	Christianity	3	Yes	COC_EK_IDI_M05
	37	Male	College/university	Married	Yes	Private security guard	Christianity	2	No	COC_ED_IDI_M01
	42	Male	Secondary	Married	Yes	Private security guard	Christianity	1	No	COC_ED_IDI_M02
	30	Male	Secondary	Not Married	No	Private security guard	Christianity	1	No	COC_ED_IDI_M03
	37	Male	College/university	Married	Yes	Civil servant	Christianity	1	No	COC_ED_IDI_M04
	28	Male	Secondary	Not Married	No	Businessman	Christianity	1	No	COC_ED_IDI_M05

(cont'd...)

Table 1. (continued)

Location	Age	Sex	Education	Marital status	Co-residence with spouse	Occupation	Religion	Number of children	Completed childbearing	Archival number
	35	Male	Secondary	Married	Yes	Businessman	Christianity	2	No	COC_ED_IDI_M06
	43	Male	College/university	Married	Yes	Civil servant	Christianity	4	Yes	COC_ED_IDI_M07
	31	Male	College/university	Married	Yes	Fashion designer	Christianity	1	No	COC_ED_IDI_M08
	35	Male	College/university	Married	Yes	Teacher	Christianity	2	Yes	COC_ED_IDI_M09
	28	Male	Secondary	Not Married	No	Mechanic	Islam	1	No	COC_ED_IDI_M010
	35	Female	College/university	Married	Yes	Managing editor	Christianity	2	No	COC_ED_IDI_W01
	35	Female	College/university	Married	Yes	Nurse	Christianity	3	Yes	COC_ED_IDI_W02
	28	Female	College/university	Married	Yes	Not reported	Christianity	1	No	COC_ED_IDI_W03
	37	Female	College/university	Married	Yes	Civil servant	Christianity	2	Yes	COC_ED_IDI_W04
	45	Female	College/university	Married	Yes	Civil servant	Christianity	3	Yes	COC_ED_IDI_W05
	39	Female	College/university	Married	Yes	Civil servant	Christianity	3	Yes	COC_ED_IDI_W06
	40	Female	Secondary	Married	Yes	Fashion designer	Christianity	3	Yes	COC_ED_IDI_W07
	32	Female	College/university	Married	Yes	Teacher	Christianity	1	No	COC_ED_IDI_W08
	35	Female	College/university	Married	Yes	Stylist	Christianity	2	Yes	COC_ED_IDI_W09
	30	Female	Secondary	Married	Yes	Businessman	Christianity	2	Yes	COC_ED_IDI_W10

2.4. Sampling

The sampling design was purposive. The sample structure for the IDI was determined by data saturation (Fusch & Ness, 2015). Data collection was conducted concurrently in both states and stopped when no new information was emerging. A total of 31 interviews were conducted in both states: 11 in Ekiti and 20 in Edo. An unspecified number of potential participants declined to participate due to time constraints.

2.5. Data collection

An IDI guide was prepared by the researchers and pretested. The guide contained questions on experiences with male COC during labor and childbirth, perceived benefits and challenges, among others. Ten data collectors, who were all postgraduate students, were recruited from the study locations and trained. The data collectors consisted of five males and five females. We formed five data collection teams, each made up of one male and one female. This arrangement was intentional to avoid reinforcing the feminization of labor and childbirth. All data collectors had at least a bachelor's degree; all but one were full-time students with no source of income. Two supervisors experienced in qualitative research supervised the data collection in the two states.

All interviews were conducted face-to-face in English and Pidgin English and were tape-recorded. All IDIs were conducted at venues convenient for the participants, and no other persons were present during the interviews. The interviews lasted an average of 45 min. Field notes were taken by the interviewers and supervisors during the interviews. Peer review of the research design, IDI guide, transcripts, and data analysis report was conducted to ensure objectivity and validity of the research.

2.6. Data analysis

All interviews and discussions were transcribed verbatim and analyzed thematically. The six stages in thematic analysis by Braun and Clarke (2021)—familiarization, systematic data coding, generating themes, developing themes, reviewing themes, and producing the report (results)—were followed in the analysis. The hybrid coding system was used, employing both deductive and inductive approaches. The deductive approach involved the identification of potential codes from the IDI guide, while other codes were identified from the data using the inductive approach. Coding and organization of the codes into themes were conducted with the aid of NVivo software (version 12, QSR International, Australia) by CAA and LFCN. The study was conducted and reported in accordance with the consolidated criteria for reporting

qualitative research guidelines.

3. Results

3.1. Study population characteristics

The characteristics of the study participants are presented in Table 1. The participants in the study were aged between 23 and 45 years, with the majority having attained a tertiary education. Approximately 51.61% had not completed childbearing, and the median number of children was 2.

3.2. Experiences of husband/partner as companion of choice during labor and childbirth

The participants shared rich and diverse experiences of a husband/partner as COC. Three broad themes with multiple sub-themes were identified from the IDIs: (i) the process and practice of husband/partner involvement as a COC; (ii) the benefits of husband/partner involvement as a COC; and (iii) the disadvantages. Participant statements are presented with sex and archival number of each interviewee. A conceptual model based on the results, anchored in the socioecological model and gender transformative perspective, is presented in Figure 1, illustrating the relationships among context, process, and outcomes.

3.3. Process and practice of male involvement as companion of choice

The participants shared diverse experiences regarding how male COCs are involved, the processes followed, and the roles they play during labor and childbirth. The results are organized into the following sub-themes: (i) male COC participation as an unwritten rule and optional, (ii) lack of prior preparation, (iii) insistence on presence, (iv) relationship with health providers, (v) very important patients (VIPs), (vi) voluntary participation/joint decision-making, (vii) role of male COC as primarily emotional support, and (viii) purpose beyond ensuring a positive birth experience.

3.3.1. Male participation as a companion of choice is often governed by unwritten rules and remains optional

There is no hospital policy on husband/partner participation as a COC during labor and childbirth in Nigeria; in some hospitals, participation is an unwritten rule, while in others, it is optional. A participant explained, "When I gave birth to my first son, at the [Hospital A], Asaba, when you're in labor, once you want to go into the labor room, you must come with your husband" (Woman, COC_ED_IDI_W06).

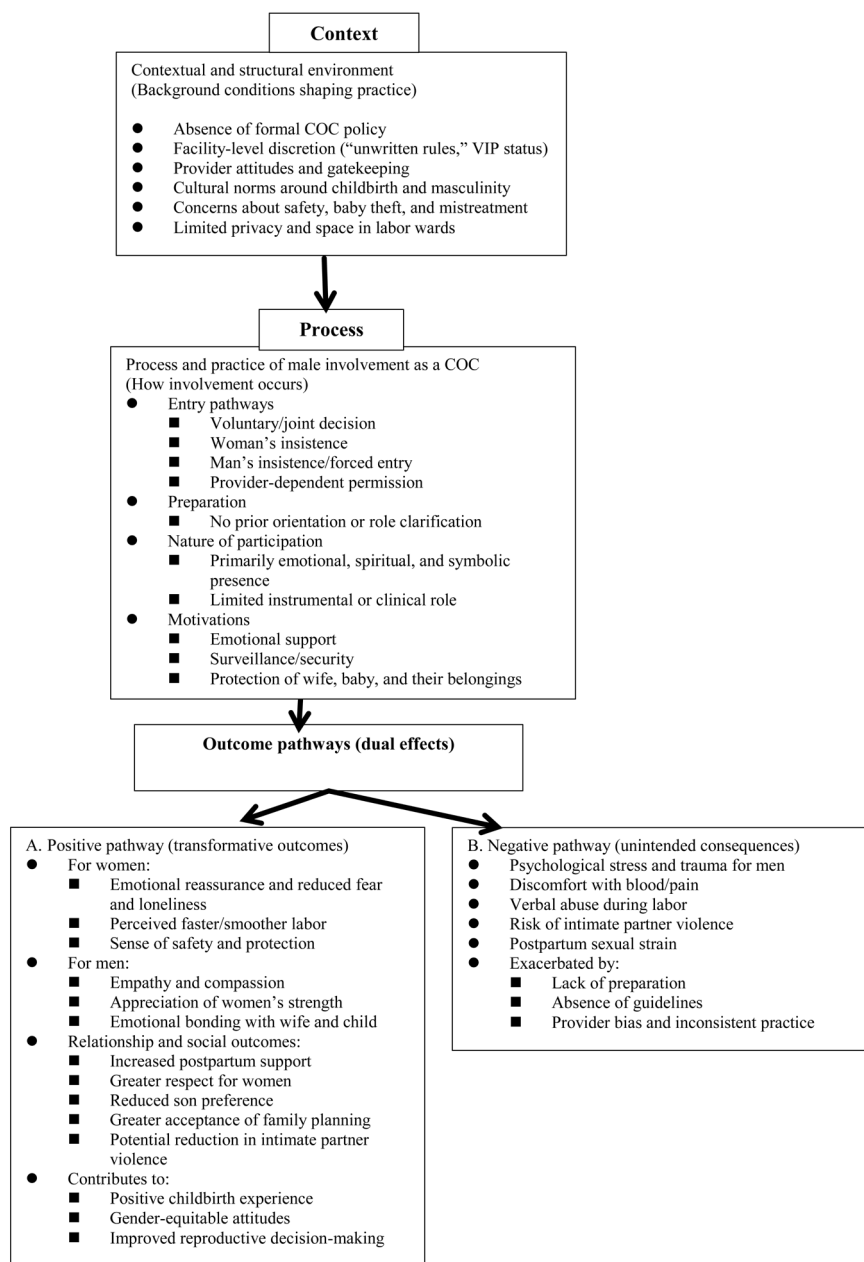


Figure 1. Conceptual model of husband/partner involvement as a COC during labor and childbirth in Nigeria
Abbreviations: COC: Companion of choice; VIP: Very important patient.

Another participant shared:

Yes, they did. Initially they will ask him, “Will he like to stay?” It is an option; if he says no, they will allow him. If he says yes, it is an option for that hospital. Based on the hospital I put to bed, they will give you an option. They will say, “Oga, do you like to stay here in the labor

ward?” He says, “Ok, I will.” If he says no... (Woman, COC_ED_IDI_W08).

3.3.2. Lack of prior preparation

Men received no prior information or preparation from the health providers regarding the roles they would play or what to expect. One participant shared “...I was not taught before, the doctor was on the job, I was asked to sanitize

my hands, and I was given gloves, so I used Dettol to wash my hands, and I changed my slippers” (Man, COC_EK_IDI_M02).

3.3.3. Insistence on presence

In some cases, husband/partner participation occurred because either the man or the woman insisted on his presence in the labor and birthing room, or the man forced his way inside. A participant shared:

Personally, I would not allow the medical practitioners to lock me outside; whatever they want to do to my wife must be done in my presence. There could be errors and imperfections, but with my presence, they can be corrected (Man, COC_EK_IDI_M03).

A participant noted, “They allowed my husband to enter because I insisted that he must enter; I just wanted to see him so that he could stay” (Woman, COC_EK_IDI_W05).

Another participant shared:

In my recent birth, the third child, they didn’t allow him to enter. The nurses were saying, “No, he can’t enter,” but when it got to some stage, I was telling him to come in. He also told the nurse, “What happened? Let me enter, after all, she is my wife.” He later forced the door open. After he had entered, I gave birth to the child, and he was there until I did the clean-up of my body and the baby. We were there together. He was the one who took me out of the labor room, and the cleaning of the feces and vomit was done by my husband (Woman, COC_EK_IDI_W02).

3.3.4. Relationship with health providers

Male involvement during labor and childbirth as a COC was influenced by the relationship between the male COC and health practitioners. Additionally, if the male COC was a medical practitioner or staff member in a private hospital, he was typically admitted into the labor and delivery room.

A participant shared, “...it also depends on your relationship with the person handling you, maybe the nurses or all those other health providers” (Woman, COC_EK_IDI_W01). Another participant explained, “Except for the guy, the husband is a medical practitioner, is either a doctor or a nurse, then they will allow him. And is a staff there, oh? Not someone outside...” (Woman, COC_ED_IDI_W09).

3.3.5. Very important patient

Male involvement during labor and childbirth as a COC was allowed when the woman was considered a VIP. A participant shared, “However, maybe the woman is a VIP, maybe a doctor is giving birth, then most of the time she will want the husband to be there” (Woman, COC_EK_IDI_W03).

3.3.6. Voluntary decision/joint decision-making

The decision to act as a COC was usually made voluntarily by the man, jointly with his spouse, or based on the woman’s preference. A participant noted, “To be realistic, it was the choice of my wife, we did not even discuss it, it was at that stage that I told the doctor that I wanted to enter, so at that stage, I told the doctor” (Man, COC_EK_IDI_M02).

Another participant explained, “It was my choice, I was there in the labor room, I loved to be there so that I would know what really happened” (Man, COC_EK_IDI_M03).

3.3.7. Role of the male companion of choice as primarily a source of emotional support

The role of husbands during labor and childbirth was primarily to provide emotional and spiritual support. A participant shared, “Yes, he did. But he didn’t stay at the front. He stood at the back because the sight of blood irritates him” (Woman, COC_ED_IDI_W08).

Another participant explained, “Actually, nothing much because we were together actually, so he was not trespassing not to the extent of maybe cautioning him or something. We were just together, he just held my hand we were praying together, so nothing more” (Woman, COC_EK_IDI_W05).

A participant further described: “...in [Church-affiliated maternity center], when you are coming to the labor room, they would have told you that you should come with your husband and that he must be present there doing all the rubbing, encouragement and everything...” (Woman, COC_EK_IDI_W06).

3.3.8. Purpose beyond ensuring a positive birth experience

Some men who participated as COCs had additional motives, such as providing security for the woman, the baby, and their belongings. A participant shared:

Firstly, something happened during my own; had it been I was not there when my wife put to bed, I wouldn’t have believed that it was my child, because the complexion really surprised me. I didn’t

believe that something this beautiful could still come out of me. (Man, COC_EK_IDI_M04)

Another participant explained, "...Nowadays things have changed. You will see a situation where baby wears are stolen. I am not accusing the nurses, but someone needs to be there to ensure that things are done properly" (Man, COC_EK_IDI_M05).

3.4. Benefits of the involvement of a husband/partner as a companion of choice

Participants expressed multiple perceived benefits of involving a husband/partner as a COC during labor and childbirth. The sub-themes include compassion and empathy, emotional and instrumental support, acceptance of family planning, reduced intimate partner violence (IPV), and mitigation of son preference.

3.4.1. Compassion, empathy, and bonding

The experience fosters compassion and empathy, particularly after witnessing labor and childbirth as a male COC. It provides men with the opportunity to appreciate the courage and resilience of women, especially their spouses. It also allows the male COC to express love and deep affection. Additionally, the labor experience promotes understanding, forgiveness, and strengthened emotional bonds within the household.

A participant shared, "I followed my wife to the labor room during our first child, and the experience was powerful, it made me acknowledge that women are really strong..." (Man, COC_EK_IDI_M03).

Another participants noted:

If husbands always go to the labor room with their wives, it will affect some of the decisions we make. If we are there when she is giving birth, before we make that decision, you would think of that day because it is between life and death (Man, COC_EK_IDI_M04).

...if you have been part of this process and you see how the child came out from a small hole, you just be wondering that my wife and my child, not over-pampering the child but would be careful with all that you do, considering that day there would be a connection with the way you are treating that wife and child (Man, COC_EK_IDI_M02).

3.4.2. Postpartum support

Male involvement as a COC enhances postnatal support. This support may include financial assistance, valuing children, and positive changes in attitude toward the family. A participant noted:

Some men use that time (when the woman is in labor) to be among friends to throw parties. That kind of person does not have human feelings. The experience I have made me know the value of children and the experience of one's wife. (Man, COC_EK_IDI_M05).

Another participant shared, "...seeing me passing through those stresses, if he is not there, maybe he will not take care of me, but as he is there, seeing me stressing like that, he will give me more money, pet me" (Woman, COC_ED_IDI_W07).

3.4.3. Emotional and spiritual support for the woman

The involvement of men as COC serves as a morale booster for the woman during labor. This support includes prayers, reduction of feelings of loneliness, and the creation of an atmosphere of love and affection for the woman/wife during labor and childbirth. A participant recounted:

I have longed for it, and it was my last pregnancy that I think by chance, my husband was allowed into the labor room. It was by chance, actually. I was in the labor ward and they needed him to get some things and then, initially, I called for him to pray for me, and so when they resisted a little, they allowed him in, after all, I was the only one in the room. I think one of the reasons they discourage it is when you have multiple pregnant women giving birth same time in the same ward, so you can't have your own partner coming in, except if it is a female, and even if it is a female, some people prefer privacy, but then he came in. I was alone and that act alone gave me the strength I thought I lost (Woman, COC_EK_IDI_W04).

One advantage illustrated by participants is emotional strength: allowing the husband to be present in the labor room gave a woman the strength to deliver the baby, which she initially felt she had lost. Other participants shared similar experiences in this regard.

Another participants noted:

It can be in the form of strength assistance to the woman or to the person involved, because at times, most women nowadays, if their husbands are not there, they will not be able to give birth. I take the case of my own, two times that my wife has given birth, I was there with her all through the process, both the delivery and the bathing of the baby. So, at that point in time, I was an additional strength to her (Man, COC_ED_IDI_M03).

...she is not doing this alone, so, yes the companionship is needed. So, she is looking around, she is seeing familiar faces, somebody that is urging her on, so the will to push. The anxiety is alleviated, fear is alleviated, she is relaxed, and she trusts the person that is next to her... (Man, COC_EK_IDI_M05).

3.4.4. Potential reduction of intimate partner violence

Participants shared that when husbands/partners act as COCs during labor and childbirth, witnessing the pains of labor and delivery firsthand may discourage them from abusing their wives.

A participant shared, "It can help! It can help because if the man is looking at the woman undergoing serious pain, especially during labor, he won't maltreat her" (Man, COC_EK_IDI_M04).

Another participants noted:

The husband easily remembers not to abuse the wife, for example, men who beat their wives are many these days. Most of them gave birth in the hospital and they were not given the privilege to experience the pains of labor, this would make men value women more (Man, COC_EK_IDI_M01).

Actually, if you allow somebody like your spouse to enter with you, number one, that man will have respect for you, at least he has experienced the pain, it will be a mad man, a mad man that sees his wife during child labor experiencing such pain, and then come back and start beating such wife or maltreating her, that means the person is mad (Woman, COC_EK_IDI_W01).

3.4.5. Commitment to family responsibility and respect for women

The involvement of a husband/partner as a COC can enhance commitment to the family, increase responsiveness to the needs of the mother and the baby, and promote respect for the wife. Participants noted:

If they make it a law, it is good. Because there are some men who don't care for their wives at all. If they enforce it as a law, it will make men to be serious about this responsibility, because you are the one that impregnated your wife. When it comes to labor and delivery, he should be a part of it (Man, COC_EK_IDI_M05).

...my thoughts about this practice, if the men are allowed into the labor ward, I will appreciate it so that they will see what the women are going through. They will now know how to respect women, they will respect their opinions, and they will respect their personality. It should not make women like errmm (stutters a bit to find the right words), what do they call it, "mama babies" (over-pampered) (Man, COC_ED_IDI_M05).

3.4.6. Facilitation of labor and safe delivery

Participants suggested that the presence of a husband and father of the baby as a COC, or as a symbolic representation of his presence, may help expedite the delivery process. A participant noted, "...so that helps to hasten the labor and to divert pain" (Woman, COC_ED_IDI_W08).

Another participant explained, "...there are also some women, if the husband is not around, their delivery may take time, unless they can see the husband's cap or any of his clothes in the labor room" (Man, COC_EK_IDI_M05).

There is a cultural belief that a COC during labor or childbirth can influence the process depending on the person's intentions toward the pregnant woman. Some women think a husband/partner may be the best as COC since he would want the good of the woman and the baby. A participant recounted:

There is a general notion that when you go with the wrong person, maybe somebody with an ulterior motive, like a diabolical person, it could delay your birth process. That is why I kept saying it has to be the partner who will want you to deliver safely, and the person that the woman shares a bond with and trusts.

It can't just be any mother-in-law, any mother, or any father, or anybody; it has to be the woman picking, having a choice (Woman, COC_EK_IDI_W04).

3.4.7. Sense of relief and safety

Male involvement during labor and childbirth as a COC provides a sense of relief to the woman and improves the overall sense of safety for the woman, the baby, and their belongings. Participants recounted:

...being beside your woman...when she sees you, she sees you by her side during the labor, she will feel relieved even though she is passing through pain, "My husband is by my side," so that is a great relief for her (Man, COC_ED_IDI_M07).

Like what happened to me in [Hospital B], there were drugs that I bought, do you believe that immediately I stepped out of the labor room, all those nurses just packed the drugs and went away. I was told to go and buy the same drugs again. Had it been that I stood there, I wouldn't even leave the place, assuming they wanted to send me on an errand I would just send somebody else and such a thing would not happen, so the material would be secured, the placenta would be secure and even the baby... (Man, COC_EK_IDI_M04).

3.4.8. Acceptance of family planning

Male involvement as a COC fosters empathy, which may promote acceptance of family planning. Male COCs who witness the delivery process, especially by their wives, may discourage closely spaced pregnancies. Sexual insistence by a male COC who is a spouse may be reduced, as he may allow the woman to rest before initiating sexual activity. Participants noted:

It can also help in family planning, it would reduce sexual insistence by men, one man in my church, the day he was allowed into the labor room during his wife's second born, said that would be the last birth (Woman, COC_EK_IDI_W01).

The male partner, seeing what the woman went through, will not want the woman to go through that all the time

and probably agree to family planning that will allow the woman to rest for a long period of time before embarking on another process (Woman, COC_ED_IDI_W10).

3.4.9. Challenges the culture of son preference

An advantage expressed in the interviews is that the tendency to have additional pregnancies to obtain a male child may be reduced when men are involved during labor and childbirth as COCs. A participant recounted:

In my own case, when I gave birth to my last child, I did not have a male child and I wanted it, but because the delivery was turbulent, my husband said that it was okay and I should not worry about having a male child and that he doesn't want me to die but he needs me to take care of my children and that was how we resolved the matter (Woman, COC_EK_IDI_W05).

3.5. Disadvantages of the involvement of husband/partner as the companion of choice during labor and childbirth

Despite the benefits, the participants expressed what they perceived as the disadvantages of husband/partner involvement as a COC during labor and childbirth.

3.5.1. Potential for intimate partner violence

A perception arising from the narratives is that male involvement as a COC during labor and childbirth may increase the risk of IPV. Some men might perceive that the woman is not cooperating adequately, which could lead to abuse.

A participant explained, "Some men might be beating the woman in labor, discouraging or tongue-lashing the person..." (Man, COC_EK_IDI_M05).

Another participant shared:

Instead of my own husband to be shouting at me, I prefer to be there alone or to be with my sister or my mom. Even this one (referring to the baby she was carrying), my husband was shouting and I don't like it, if not that I have patience, I would have bitten him (Woman, COC_ED_IDI_W01).

3.5.2. Postpartum sexual challenges

Male involvement during labor and childbirth as a COC

may affect the couple's sexual relationship after the delivery, due to what the male COC witnessed during the birthing process. A participant explained:

The disadvantage, as I said, it can slow down or even distort their sexual life. It can also bring resentment in the sense that the man will be looking at his wife like, a lot has changed. Meanwhile, it is not like that (Woman, COC_ED_IDI_W07).

3.5.3. Psychological trauma

Male involvement as a COC exposes men to blood and the intensity of the birthing process, which some may find difficult to tolerate. Additionally, some participants reported experiencing psychological distress, particularly men participating for the first time. A participant noted:

To some of them... I am just saying that it could be, it could be, at the end of the day, it is still one word, "trauma," because seeing that kind of process that you have not experienced before takes a lot to assimilate all that in, and then you are now looking at your wife like this actually happened... (Man, COC_ED_IDI_M07).

Another participant shared, "The only disadvantages that could be there is that some men cannot stand the sight of blood and when their loved ones are in pain" (Man, COC_ED_IDI_M03).

3.6. Conceptual model of husband/partner involvement as a companion of choice during labor and childbirth in Nigeria

The model in **Figure 1** depicts how male participation as a COC operates within a healthcare system where the practice of COC is unregulated, and within the sociocultural context that shapes participation processes, producing both positive and unintended negative outcomes. While male companionship during labor and childbirth promotes emotional support, empathy, improved postpartum support, acceptance of family planning, and challenges harmful gender norms, the absence of formal policies and adequate preparation of the COC may also lead to emotional distress, IPV, and strain in sexual relationships. Policy regulation, health provider training, and antenatal preparation to moderate these pathways are therefore critical for maximizing benefits and minimizing harm.

4. Discussion

This study examined the perceptions of men and women

who had experienced male involvement as a COC during labor and childbirth in Nigeria. The findings show that there is no written regulation governing COC practice in the hospitals where male involvement as a COC is practiced. In some cases, the man gained entry into the labor and birthing room, and involvement may depend on the relationship with the health providers.

The role of the male COC is not specified; consequently, they primarily provide emotional and spiritual support, and they are not usually prepared beforehand. A lack of preparation was also reported in a study in Malawi (Kungwimba *et al.*, 2013), unlike the practice in more developed settings, where the man's role is clearly specified, and he is prepared beforehand (Schmitt *et al.*, 2022). The unregulated practice, as described by the participants, may give room for the violation of women's right to a positive birth experience (Dahlen, 2020; World Health Organization, 2020), and for experiences that may have unintended negative effects on men's mental and sexual health (Schmitt *et al.*, 2022).

Active roles for the male COC, such as helping to cut the umbilical cord, could be specified, and the men should be prepared beforehand, as in more developed settings, to maximize the positive outcomes and reduce the adverse effects (King, 2017; Kinrade, 2023; World Health Organization, 2020). Male involvement was also practiced for reasons other than providing the woman with a positive experience during labor and childbirth, such as ensuring the safety of the woman, the baby, and their belongings. This finding supports results from a multi-country study in Ghana, Nigeria, Guinea, and Myanmar that associated the absence of a companion during labor with abuse, mistreatment, and longer waiting times (Balde *et al.*, 2022).

Despite the unregulated practice and the passive role of men who are involved, the participants narrated what they perceived as the benefits. Some of the perceived benefits include the fast-tracking of the birthing process, bonding and commitment to family, support during and after birth, and a sense of relief and safety during birth. Studies in other settings, including those summarized in systematic reviews, reported similar benefits, indicating that paternal participation during labor and childbirth increases bonding with the spouse and baby, financial and other forms of commitment to the family, and a sense of inclusion in the birth process due to shared experiences and emotions during labor and childbirth (Bohren *et al.*, 2019; Coutinho *et al.*, 2016; Uribe-Torres *et al.*, 2021).

Additionally, the findings show that male involvement as a COC may encourage respect for women and the adoption of family planning, and deter IPV and son preference. These findings suggest the potential of male

involvement as a COC to contribute to Nigeria's progress toward achieving the Sustainable Development Goals related to gender equality and maternal and child health (World Health Organization, 2016).

The findings on respect for women, son preference, and IPV indicate that the involvement of husbands/partners as COCs will positively challenge gender bias, thereby improving the country's gender development outcomes. Nigeria is among the countries with a low gender development index (0.863) in 2021, and between 2017 and 2022, only 0.87% of women and 0.00% of men in Nigeria were reported to have no gender social norms bias (United Nations Development Programme, 2023), and three in every 10 Nigerian women in a union experience IPV (National Population Commission of Nigeria & ICF, 2019). The findings of this study demonstrate that involving men as COCs not only improves respect for women but also has the potential to reduce the prevalence of IPV in Nigeria.

Nigeria has one of the lowest contraceptive prevalence rates in sub-Saharan Africa. In 2023, the percentage of currently married women of reproductive age who used any contraceptive was 20% (Federal Ministry of Health and Social Welfare of Nigeria, National Population Commission of Nigeria, and ICF, 2024), compared with 62.5% in Kenya and 36.3% in Ghana in 2022 (Ghana Statistical Service & ICF, 2024; Kenya National Bureau of Statistics & ICF, 2023). Evidence from this study shows that male involvement as a COC may encourage birth spacing and family planning, thus improving contraceptive prevalence in the country. One of the critical factors associated with the high maternal and child mortality in Nigeria is high parity and short birth intervals (Budu *et al.*, 2021; Ntoimo *et al.*, 2018). This finding on family planning indicates that involving men as COCs also has the potential to contribute to reductions in maternal mortality as birth intervals increase and the desired number of children decreases.

The findings on family planning and son preference also suggest that involving husbands/partners in the labor and birthing process may serve as a potential strategy to challenge the sociocultural factors that discourage small family size in Nigeria. The total fertility rate in Nigeria, currently 4.8, is one of the highest in Africa, and the transition has remained significantly slow, despite the country's policy to reduce the total fertility rate by 0.6 annually (Federal Ministry of Health and Social Welfare of Nigeria, National Population Commission of Nigeria, and ICF, 2024; National Population Commission, 2021). The slow fertility transition in Nigeria has been explained from several perspectives, particularly the low utilization of contraceptives due to preferences for larger family, son preference, and other sociocultural and religious factors

(Addah & Ikobho, 2022; Bongaarts, 2020; Bongaarts & Casterline, 2013; Ntoimo, 2022).

Despite these advantages, several disadvantages were also perceived. Male involvement may increase IPV if the man thinks the woman is not exerting sufficient effort or is misbehaving during labor or childbirth. This might lead to IPV during labor and childbirth or afterward. If the practice is regulated and men are informed about what to expect, this perceived disadvantage may be minimized. Other perceived disadvantages included postpartum sexual strain and trauma. However, consistent with previous studies, the benefits of husband/partner involvement as a COC, as observed in this study, outweigh these perceived disadvantages (Bohren *et al.*, 2017) and are likely to remain minimal if the men are adequately informed beforehand.

Many studies in Nigeria have documented women's desire to have their husbands/partners as their COC throughout labor and childbirth. In one study, 80.8% of women preferred male partners as their COC (Morhason-Bello *et al.*, 2009), and in another study in southwest Nigeria, 65% preferred husbands as their COC (Ibitoye & Phetlhu, 2018). The findings of this study provide valuable evidence supporting the implementation of a policy on husband/partner involvement as a COC during labor and childbirth in Nigeria, as a strategy to improve women's childbirth experience, gender equality, maternal health, pregnancy outcomes, and facilitate fertility transition. Nevertheless, in implementing such a policy, women's right to choose their COC should not be compromised (World Health Organization, 2020). While the majority of Nigerian women prefer their husbands/partners as their COC during labor, some women are hesitant due to personal embarrassment, fear of loss of sexual attractiveness, and lack of privacy (Oboro *et al.*, 2011).

Through the lens of the integrated theoretical framework that guided this study, as posited in the socioecological model, the findings demonstrate that the experience of husband/partner involvement as a COC during labor and childbirth is shaped by multiple interrelated levels of influence, including structural and policy environments, health facility practices, interpersonal relationships, and individual choices. The absence of a formal COC policy, provider discretion, facility constraints, and prevailing sociocultural norms shape how male involvement is practiced, the roles men assume, and the degree of preparation provided. These contextual factors influence the processes through which husband/partner involvement occurs, including voluntary or coerced entry, lack of role clarification, and motivations that extend beyond supporting a positive childbirth experience.

From the perspective of gender transformation, the

findings depict how husband/partner involvement as a COC both reinforces and challenges existing gender roles, norms, and power relations within unions. The potential benefits of male involvement as a COC during labor and childbirth include challenging existing gender norms, fostering empathy, promoting respect for women's bodily labor, encouraging shared responsibilities, and supporting more equitable decision-making. These potentials are reflected in findings such as improved postpartum support, acceptance of family planning, reduced son preference, and the potential reduction of IPV. Conversely, in the absence of adequate preparation and oversight, husband/partner involvement as a COC may produce unintended consequences, including psychological distress, verbal abuse during labor, IPV, and postpartum sexual strain.

The findings have implications for policy and practice. The current lack of standardized policies regarding male involvement as a COC during labor and childbirth results in inconsistent practice. The government should develop policies with national guidelines that support and recognize male involvement as a valid option during labor and childbirth. This should include ensuring that policies and guidelines are effectively communicated to healthcare providers and institutions. A national guideline or policy would promote equity in women's access to husbands/partners as a COC. Currently, VIPs and those with insider connections are more likely to obtain permission for husband/partner involvement, creating inequities. The findings also highlight security and accountability concerns. Some husbands/partners participated as COCs to prevent baby theft or mistreatment of the wife or baby, reflecting mistrust in the health system and emphasizing the need to improve transparency and monitoring within maternity services. Clear post-delivery verification procedures are also needed to reduce the fear of baby mix-ups.

Public health campaigns highlighting the benefits of husband/partner involvement as COCs and addressing cultural myths and other challenges to implementing male COCs during labor and childbirth are needed. Antenatal classes should include sessions for couples, equipping men with the knowledge and skills to provide effective support as COCs. The findings underscore the need for training and retraining of healthcare providers to understand the importance of male involvement as a COC, overcome cultural and personal biases, and develop skills for working with couples during labor and childbirth. Such training would contribute to respectful maternity care models that recognize male presence as part of the supportive birth environment. Health institutions may also need to

redesign labor wards to ensure privacy and comfort for both the woman and her companion.

5. Strengths and limitations

A major strength of this study is its qualitative design, the wider geographic scope involving two states, and the inclusion of men who have been involved as COCs and women whose husbands/partners have served as their COC during labor and childbirth. This represents a departure from previous studies, which were either facility-based, quantitative, or conducted in a single location. The findings have broadened the understanding of the practice of COC in Nigeria, thereby providing useful insights for future research, policy, and programmatic interventions. Limitations of the study include a small sample size and the fact that the findings reflect the subjective experiences and perspectives of participants, which cannot be generalized to the larger Nigerian population. However, they provide valuable insights for implementing policies to harness the benefits of male involvement as COC during labor and childbirth while minimizing potential disadvantages.

6. Conclusion

This research provides important qualitative evidence on husband/partner involvement as a COC during labor and childbirth in Nigeria. In the absence of formal policies, male involvement is practiced inconsistently, with unclear roles and limited preparation, creating risks to women's rights, men's wellbeing, and equitable access. Nevertheless, participants reported substantial benefits, including emotional support, strengthened bonding, enhanced respect for women, increased acceptance of family planning, reduced son preference, and potential reductions in IPV. These findings indicate that structured male involvement may contribute not only to improved childbirth experiences but also to broader gender transformation, fertility transition, and maternal health outcomes in Nigeria. However, without regulation and preparation, unintended harms may occur. Developing national guidelines, integrating couple-focused antenatal education, training providers, and improving facility infrastructure are critical to institutionalizing respectful and equitable male involvement. While the findings are not generalizable, they provide actionable insights to inform reproductive health policy and programmatic reforms in Nigeria.

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Conflict of interest

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Ethics approval and consent to participate

The study was fully explained to participants by the data collectors, and written informed consent was obtained from each participant. Participation was voluntary. Participants were assured of the anonymity and confidentiality of the information provided. All direct identifiers are removed from the data presented in this paper. Ethical approval for the study was obtained from the Research Ethics Committee, College of Medical Sciences, University of Benin, Benin City, Nigeria (ethical approval number: CMS/REC/2022/011; approval date: September 13, 2022).

Consent for publication

Participants gave verbal consent for the publication of their anonymous data.

Availability of data

The data associated with this article is not available for open sharing because we did not obtain permission from the participants to share the data. However, a reasonable request to the following organization will be considered: Women's Health and Action Research Centre (WHARC), Km 11, Benin-Lagos Expressway, Igwe-Iheya, Benin City, Edo State, Nigeria. Email: info@wharconline.org. Telephone: 8023105456; 8125917652

References

- Addah, A., & Ikobho, E. (2022). Demographic and fertility transition in Nigeria; the progress made so far: A literature review. *Babcock University Medical Journal*, 5(2), 110-116.
<https://doi.org/10.38029/babcockunivmedj.v5i2.135>
- Adeniran, A. S., Aboyeji, A. P., Fawole, A. A., Balogun, O. R., Adesina, K. T., & Adeniran, P. I. (2015). Male Partner's role during pregnancy, labour and delivery: Expectations of pregnant women in Nigeria. *International Journal of Health Sciences*, 9(3), 301-309.
<https://doi.org/10.12816/0024697>
- Adeyemi, A. B., Fatusi, A. O., Phillips, A. S., Olajide, F. O., Awowole, I. O., & Orisawayi, A. O. (2018). Factors associated with the desire for companionship during labor in a Nigerian community. *International Journal of Gynecology & Obstetrics*, 141(3), 360-365.
<https://doi.org/10.1002/ijgo.12471>
- Aládésanmí, O. A., & Ògúnjínmí, Ì. B. (2019). Yorùbá Thoughts and Beliefs in Child Birth and Child Moral Upbringing: A Cultural Perspective. *Advances in Applied Sociology*, 9(12), 569-585.
<https://doi.org/10.4236/aasoci.2019.912041>
- Asogwa, S. U., Nwafor, J. I., Obi, C. N., Ibo, C. C., Ugoji, D.-P. C., Ebere, I. C., Adiele, A. N., & Olaleye, A. A. (2019). A Study on the Attitude and Preference of Antenatal Clinic Attendees to Companionship during Labour and Delivery in Alex Ekwueme Federal University Teaching Hospital, Abakaliki. *Advances in Reproductive Sciences*, 7(04), 71.
<https://doi.org/10.4236/arsci.2019.74009>
- Balde, M. D., Nasiri, K., Mehrtash, H., Soumah, A.-M., Bohren, M. A., Diallo, B. A., Irinyenikan, T. A., Maung, T. M., Thwin, S. S., Aderoba, A. K., Vogel, J. P., Mon, N. O., Adu-Bonsaffoh, K., & Tunçalp, Ö. (2020). Labour companionship and women's experiences of mistreatment during childbirth: Results from a multi-country community-based survey. *BMJ Global Health*, 5(Suppl 2), e003564.
<https://doi.org/10.1136/bmjgh-2020-003564>
- Bangal, V., Bayaskar, V., Arjun, A., Khan, I., & Thorat, U. (2018). Opinions of pregnant women regarding desire and choice of labour companion. *MOJ Womens Health*, 7(4), 114-118.

<https://doi.org/10.15406/mojwh.2018.07.00180>

Bohren, M. A., Berger, B. O., Munthe-Kaas, H., & Tunçalp, Ö. (2019). Perceptions and experiences of labour companionship: A qualitative evidence synthesis. *Cochrane Database of Systematic Reviews*, 2019(7).

<https://doi.org/10.1002/14651858.CD012449.pub2>

Bohren, M. A., Hazfiarini, A., Vazquez Corona, M., Colomar, M., De Mucio, B., Tunçalp, Ö., & Portela, A. (2023). From global recommendations to (in) action: A scoping review of the coverage of companion of choice for women during labour and birth. *PLoS Global Public Health*, 3(2), e0001476.

<https://doi.org/10.1371/journal.pgph.0001476>

Bohren, M. A., Hofmeyr, G. J., Sakala, C., Fukuzawa, R. K., & Cuthbert, A. (2017). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, 7, 2017(8).

<https://doi.org/10.1002/14651858.CD003766.pub6>

Bongaarts, J. (2020). Trends in fertility and fertility preferences in sub-Saharan Africa: The roles of education and family planning programs. *Genus*, 76(1), 32.

<https://doi.org/10.1186/s41118-020-00098-z>

Bongaarts, J., & Casterline, J. (2013). Fertility Transition: Is sub-Saharan Africa Different? *Population and Development Review*, 38(s1), 153-168.

<https://doi.org/10.1111/j.1728-4457.2013.00557.x>

Braun, V., & Clarke, V. (2021). *Thematic Analysis: A Practical Guide*. SAGE Publications. Available from: <https://books.google.com.ng/books?id=mToqEAAAQBAJ> [Last accessed on 2024 Nov 22].

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32(7), 513-531.

<https://doi.org/10.1037/0003-066X.32.7.513>

Budu, E., Ahinkorah, B. O., Ameyaw, E. K., Seidu, A.-A., Zegeye, B., & Yaya, S. (2021). Does Birth Interval Matter in Under-Five Mortality? Evidence from Demographic and Health Surveys from Eight Countries in West Africa. *BioMed Research International*, 2021(1), 5516257.

<https://doi.org/10.1155/2021/5516257>

Coutinho, E. C., Antunes, J. G. V. C., Duarte, J. C., Parreira, V. C., Chaves, C. M. B., & Nelas, P. A. B. (2016). Benefits for the father from their involvement in the labour and birth sequence. *Procedia-Social and Behavioral Sciences*, 217, 435-442.

<https://doi.org/10.1016/j.sbspro.2016.02.010>

Dahlen, H. G. (2020). It is time to consider labour companionship as a human rights issue. *Evidence-Based Nursing*, 23(3), 78.

<https://doi.org/10.1136/ebnurs-2019-103127>

Federal Ministry of Health and Social Welfare of Nigeria, National

Population Commission of Nigeria, & ICF. (2024). Nigeria Demographic and Health Survey 2023–24: Key Indicators Report. NPC and ICF. Available from: <https://dhsprogram.com/pubs/pdf/PR157/PR157.pdf> [Last accessed on 2024 Oct 14].

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report*, 20(9), 1408.

<https://doi.org/10.46743/2160-3715/2015.2281>

Ghana Statistical Service, & ICF. (2024). *Ghana Demographic and Health Survey 2022*. GSS and ICF. Available from: <https://www.dhsprogram.com/pubs/pdf/FR387/FR387.pdf> [Last accessed on 2024 Feb 10].

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*, 3(1), 42-55.

<https://doi.org/10.1177/160940690400300104>

Ibitoye, O. F., & Phetlhu, D. R. (2018). Women and continuous labour support in public health facilities in Nigeria. *Africa Journal of Nursing and Midwifery*, 20(2), 1-15.

<https://doi.org/10.25159/2520-5293/4036>

Kabakian-Khasholian, T., & Portela, A. (2017). Companion of choice at birth: Factors affecting implementation. *BMC Pregnancy and Childbirth*, 17(1), 265.

<https://doi.org/10.1186/s12884-017-1447-9>

King, L. (2017). Hiding in the Pub to Cutting the Cord? Men's Presence at Childbirth in Britain, 1940s–2000s. *Social History of Medicine*, 30(2), 389-407.

<https://doi.org/10.1093/shm/hkw057>

Kinrade, S. H. (2023). Reducing the Adverse Effects of Birth Trauma Among Birth Companions. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 52(6), 509–519.

<https://doi.org/10.1016/j.jogn.2023.08.001>

Kenya National Bureau of Statistics, & ICF. (2023). *Kenya Demographic and Health Survey 2022: Volume 1*. Kenya National Bureau of Statistics (KNBS) and ICF. Available from: <https://dhsprogram.com/pubs/pdf/FR380/FR380.pdf> [Last accessed on 2024 Nov 04].

Kungwimba, E., Maluwa, A., & Chirwa, E. (2013). Experiences of women with the support they received from their birth companions during labour and delivery in Malawi. *Health*, 5(1), 45-52.

<https://doi.org/10.4236/health.2013.51007>

Lamsal, P., Aryal, V., Adhikari, A., & Roka, Y. (2024). Male Involvement in Sexual and Reproductive Health and Rights. *INTELLIGENCE Journal of Multidisciplinary Research*, 3(1), 151-164.

<https://doi.org/10.3126/ijmr.v3i1.65483>

MacArthur, J., Carrard, N., Davila, F., et al. (2022). Gender-

- transformative approaches in international development: A brief history and five uniting principles. *Women's Studies International Forum*, 95, 102635.
<https://doi.org/10.1016/j.wsif.2022.102635>
- Mbadugha, C. J., Anetekhai, C. J., Obiekwu, A. L., Okonkwo, I., & Ingwu, J. A. (2019). Adult male involvement in maternity care in Enugu State, Nigeria: A cross-sectional study. *European Journal of Midwifery*, 3, 16.
<https://doi.org/10.18332/ejm/112258>
- Morhason-Bello, I. O., Adedokun, B. O., & Ojengbede, O. A. (2009). Social support during childbirth as a catalyst for early breastfeeding initiation for first-time Nigerian mothers. *International Breastfeeding Journal*, 4(1), 1-7.
<https://doi.org/10.1186/1746-4358-4-16>
- Morhason-Bello, I. O., Olayemi, O., Ojengbede, O. A., Adedokun, B. O., Okuyemi, O. O., & Orji, B. (2008). Attitude and preferences of Nigerian antenatal women to social support during labour. *Journal of Biosocial Science*, 40(4), 553-562.
<https://doi.org/10.1017/S0021932007002520>
- National Bureau of Statistics and United Nations Children's Fund. (2022). *Multiple Indicator Cluster Survey 2021, Survey Findings Report*. National Bureau of Statistics and United Nations Children's Fund. Available from: <https://www.unicef.org/nigeria/media/6316/file/2021%20MICS%20full%20report%20.pdf> [Last accessed on 2022 Sep 26].
- Federal Government of Nigeria. (2021). National Policy on Population for Sustainable Development. National Population Commission. Available from: <https://africahbn.info/wp-content/uploads/2022/04/Nigeria-2022-Revised-National-Policy-on-Population-for-Sustainable-Development.pdf> [Last accessed on 2022 Feb 10].
- National Population Commission of Nigeria, & ICF. (2019). *Nigeria Demographic and Health Survey 2018*. NPC and ICF. Available from: <https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf> [Last accessed on 2019 Nov 06].
- Ntoimo, L. F. C. (2022). Family size preferences among women in a union in Nigeria and associated factors. *International Journal of Population Studies*, 7(1), 51-65.
<https://doi.org/10.18063/ijps.v7i1.1318>
- Ntoimo, L. F., Okonofua, F. E., Ogu, R. N., Galadanci, H. S., Gana, M., Okike, O. N., Agholor, K. N., Abdus-Salam, R. A., Durodola, A., Abe, E., & Randawa, A. J. (2018). Prevalence and risk factors for maternal mortality in referral hospitals in Nigeria: A multicenter study. *International Journal of Women's Health*, 10, 69-76.
<https://doi.org/10.2147/IJWH.S151784>
- Oboro, V. O., Oyeniran, A. O., Akinola, S. E., & Isawumi, A. I. (2011). Attitudes of Nigerian women toward the presence of their husband or partner as a support person during labor. *International Journal of Gynecology & Obstetrics*, 112(1), 56-58.
<https://doi.org/10.1016/j.ijgo.2010.07.033>
- Olayemi, O., Bello, F. A., Aimakhu, C. O., Obajimi, G. O., & Adekunle, A. O. (2009). Male participation in pregnancy and delivery in Nigeria: A survey of antenatal attendees. *Journal of Biosocial Science*, 41(4), 493-503.
<https://doi.org/10.1017/S0021932009003356>
- Rungreangkulkij, S., Ratinthorn, A., Lumbiganon, P., et al. (2022). Factors influencing the implementation of labour companionship: Formative qualitative research in Thailand. *BMJ Open*, 12(5), e054946.
<https://doi.org/10.1136/bmjopen-2021-054946>
- Schmitt, N., Striebich, S., Meyer, G., Berg, A., & Ayerle, G. M. (2022). The partner's experiences of childbirth in countries with a highly developed clinical setting: A scoping review. *BMC Pregnancy and Childbirth*, 22(1), 742.
<https://doi.org/10.1186/s12884-022-05014-1>
- Senanayake, H., Wijesinghe, R. D., & Nayar, K. R. (2017). Is the policy of allowing a female labor companion feasible in developing countries? Results from a cross sectional study among Sri Lankan practitioners. *BMC Pregnancy and Childbirth*, 17, 1-6.
<https://doi.org/10.1186/s12884-017-1578-z>
- Sharma, V., Leight, J., Giroux, N., AbdulAziz, F., & Nyqvist, M. B. (2019). "That's a woman's problem": A qualitative analysis to understand male involvement in maternal and newborn health in Jigawa state, northern Nigeria. *Reproductive Health*, 16(1), 143.
<https://doi.org/10.1186/s12978-019-0808-4>
- The United Nations Inter-agency Group for Child Mortality Estimation. (2023). *Levels & Trends in Child Mortality*. UNICEF. Available from: <https://data.unicef.org/resources/levels-and-trends-in-child-mortality-2023/> [Last accessed on 2024 May 08].
- Umeora, O. U. J., Ukkaegbe, C. I., Eze, J. N., & Masekoameng, A. K. (2011). Spousal companionship in labor in an urban facility in South East Nigeria. *International Journal of Gynecology & Obstetrics*, 112(1), 56-58.
- United Nations Development Programme. (2023). *2023 Gender Social Norms Index Breaking Down Gender Biases Shifting social norms towards gender equality*. Available from: <https://hdr.undp.org/content/2023-gender-social-norms-index-gsni/indicies/GSNI> [Last accessed on 2024 Feb 10].
- Uribe-Torres, C., Serrano, M. M., & Hoga, L. (2021). Father prepared, committed, and involved in his child's birth: The experience of early father-child skin to skin contact at birth. *Open Journal of Obstetrics and Gynecology*, 11(7), 853-867.
<https://doi.org/10.4236/ojog.2021.117080>
- Vehviläinen-Julkunen, K., & Emelonye, A. U. (2014). Spousal

participation in labor and delivery in Nigeria. *Annals of Medical and Health Sciences Research*, 4(4), 511-515.

<https://doi.org/10.4103/2141-9248.139290>

World Health Organization. (2016). *World health statistics 2016: Monitoring health for the SDGs, sustainable development goals*. World Health Organization. Available from: <https://www.who.int/publications/i/item/9789241565264> [Last accessed on 2017 Mar 13].

World Health Organization. (2018). *WHO recommendations: Intrapartum care for a positive childbirth experience* (Licence: CC BY-NC-SA 3.0 IGO). World Health Organization. Available from: <https://www.who.int/publications/i/item/9789241550215> [Last accessed on 2019 Aug 17].

World Health Organization. (2020). *Companion of choice during labour and childbirth for improved quality of care: Evidence-to-action brief, 2020*. World Health Organization.

Available from: <https://apps.who.int/iris/bitstream/handle/10665/334151/WHO-SRH-20.13-eng.pdf> [Last accessed on 2022 May 16].

World Health Organization. (2025). *Trends in maternal mortality estimates 2000 to 2023: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division*. World Health Organization. Available from: <https://www.who.int/publications/i/item/9789240108462> [Last accessed on 2025 Apr 16].

Yaya Bocoum, F., Kabore, C. P., Barro, S., Zerbo, R., Tiendrebeogo, S., Hanson, C., Dumont, A., Betran, A. P., & Bohren, M. A. (2023). Women's and health providers' perceptions of companionship during labor and childbirth: A formative study for the implementation of WHO companionship model in Burkina Faso. *Reproductive Health*, 20(1), 46.

<https://doi.org/10.1186/s12978-023-01597-w>