



Birth Preparedness and Complication Readiness of Men in Uyo Local Government Area, Akwa Ibom State, Nigeria

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ABSTRACT: This study examined the personal characteristics, knowledge, and attitudes of expectant fathers in Uyo, Nigeria, towards birth preparedness and complication readiness (BP/CR). Utilizing a convenience sample of 120 expectant fathers, the research explored how factors such as age, marital status, occupation, and education level influenced their understanding of and engagement in maternal health practices. Data obtained were analyzed using both descriptive and inferential statistics such as frequency and correlation. The results indicated that most fathers were in their prime reproductive years (65, 54.2%), predominantly Christians (116, 96.7%), married (72, 60%), and employed (96, 80%), often as businessmen or traders (66, 55%) with a tertiary level of education (82, 68.3%). Also, majority demonstrated high knowledge (100, 83.3%) and positive attitudes towards BP/CR (84, 70%), with marital status (0.993), occupation (0.949), and number of children (0.964) showing strong correlations with favorable attitudes ($p < 0.01$). These findings underscore the importance of socio-cultural factors in shaping paternal involvement in maternal health, advocating for targeted interventions that consider these variables to enhance male participation in maternal care and improve maternal and neonatal outcomes.

KEYWORDS: Birth preparedness, complication readiness, expectant fathers, paternal involvement, maternal health, Nigeria

INTRODUCTION

Birth preparedness and complication readiness (BP/CR) is a vital strategy aimed at reducing maternal and neonatal risks by encouraging proactive planning for pregnancy-related emergencies (Pal et al., 2024). Traditionally, maternal health programs have focused primarily on expectant mothers, but recent studies highlight the significant role that expectant fathers can play in supporting their partners. When fathers are informed and engaged, they help ensure that their partners attend antenatal care, receive skilled delivery services, and are prepared for emergencies (Onyeze-Joe and Godin, 2020).

Globally, maternal and neonatal morbidity and mortality remain major public health challenges, especially in low- and middle-income countries where access to quality emergency obstetric care is limited (Ekwuazi et al., 2023). The BP/CR process as a core strategy to reduce delays in seeking, reaching, and receiving timely healthcare (Habte et al., 2023). This planning involves recognizing danger signs during pregnancy, arranging transport to health facilities, and setting aside financial resources for emergencies (Tony-Igwe et al., 2024). Research shows that when men are well-informed about these aspects, they actively support their partners and contribute to better pregnancy outcomes (Comrie-Thompson et al., 2021).

However, studies have also found that many expectant fathers still have limited knowledge of BP/CR and may hold attitudes that reduce their involvement in maternal healthcare (Okafor et al., 2022). Cultural norms and traditional gender roles often assign pregnancy and childbirth solely to women, which can result in delayed decision-making during emergencies and negative health outcomes (Yuill et al., 2020). In some communities, where male partners typically control household finances and decision-making, their awareness and supportive attitude towards BP/CR become even more critical (Adamu et al., 2020).

Research on expectant fathers' knowledge and attitudes toward BP/CR is essential for developing interventions that enhance male involvement in maternal health. Studies indicate that when fathers receive comprehensive information about the risks and necessary preparations, they are more likely to accompany their partners to antenatal care, make emergency plans, and advocate for skilled birth attendance (Simkin and Cheyney, 2024). Yet, gaps remain in understanding how personal characteristics such as age, education, occupation, and cultural context affect these knowledge levels and attitudes. Therefore, this study aims to fill these gaps by examining the personal characteristics of expectant fathers, assessing their knowledge of BP/CR, and exploring how cultural beliefs and experiences shape their attitudes. By doing so, the findings will inform policies and programs that promote male involvement in maternal healthcare, ultimately leading to improved maternal and neonatal outcomes.



METHODOLOGY

i. Study Area

The study was carried out in Uyo Local Government Area (L.G.A.) of Akwa Ibom State. Uyo L.G.A. lies between 458 and 505N latitudes and between 754 and 800E. it is located on Latitude: 5° 03' and 4.57" N and Longitude: 7° 56' and 0.60" E. Its metropolis sprawls into the adjoining local government areas of Itu, Ibiono Ibom and Uruan Local Government Areas (Jacob et al., 2024; 2017). Uyo Capital City is bounded in the North by Itu and Uruan L.G.A. and on the South by Uruan L.G.A. and encompasses parts of other L.G.A. like Uruan, Itu, Ibesikpo Asutan, Nsit Ibom and Etinan. Uyo L.G.A. has a relatively high mean annual rainfall of more than 2500mm and a mean annual temperature of 27° C. People residing in the city engage in several occupations which range from the civil and public services, industrial and commercial business to farming in parts of the urban area (Ukpong et al., 2023; Nelson et al., 2017). Uyo L.G.A. is the capital of Akwa Ibom State, Nigeria with a population of 305,961 comprising 155,698 males and 150,263 females (National Population Commission, 2006). The population is projected at 1.5% annual rise. Uyo L.G.A. has four clans (Oku, Ikono, Etoi and Offot), eleven political wards and seventy-five villages.

ii. Sampling Technique and Data Collection

The convenience sampling procedure was used to select 120 expectant fathers for this study through visits to primary health facilities and churches where wives/partners of the expectant fathers were easily accessed. The use of convenience sampling was adopted because of ease of access to the respondents who otherwise could not be easily accessed since there are no definite official figure of a population of expectant fathers in the study area by governmental and non-governmental agencies.

A well-constructed questionnaire reflecting the specific objectives of the study was used to elicit data from the expectant fathers. The personal characteristics of the respondents were analyzed using frequency counts, percentages and means. The respondents' knowledge of birth preparedness and complications readiness was measured using a 12-statement scale named Knowledge of Birth preparedness and Complications readiness Scale (KBCS). Response to statements in the KBCS were captured on a 4-point scale of Strongly Disagree (SD), Disagree(D), Agree(A) and Strongly Agree(SA) scored 1, 2, 3 and 4 respectively. All individual answers to the statements in the scale were computed to obtain a total KBCS score range of 12-48 with a mean of 30. The mean score (30) was then used to categorize the respondents' knowledge level of birth preparedness and complications readiness into low (<30) and high (≥30).

The respondents' attitude towards birth preparedness and complications readiness in Uyo L.G.A. was surveyed using an 8-statement Attitude towards Birth preparedness and Complications readiness Scale (ABCS). Response categories on the ABCS ranged from 1 (Strongly Disagree) to 4 (Strongly Agree). All individuals' answers to statements were computed to obtain total scores with the range 8 – 32 with a mean of 20. The mean score (20) served as a cut-off point between favourable attitude (≥20) and unfavourable attitude (<20).

Validation of Research Instrument

The research instrument was a structured questionnaire used to gather primary data from the field for analysis. The questionnaire was divided into sections. The questionnaire was prepared in line with the study's objectives in order to meet the study's goals. To ascertain that the research instrument (questionnaire) was adequate enough to achieve the result, it was validated by a professional in the Department of Home Economics, University of Uyo. The instrument was examined for corrections and suggested restructuring where made as necessary. The research instrument was subjected to face and content validation.

Reliability of the Research Instrument

To make sure the survey instrument was reliable, the researcher conducted a test-retest process. This entails testing the instrument multiple times and measuring its consistency. The resulting reliability index of 0.78 was obtained, indicating that the instrument is indeed reliable and can be trusted to produce consistent results over time (Reis and Judd, 2000).

Data Analysis

Data for the study were derived from the questionnaires administered randomly to 120 respondents in the study area. All the questionnaires administered were retrieved from the respondents for analysis. The collected data were analyzed using both descriptive and inferential statistics such as frequency counts, percentages, means and correlation. All these analysis were conducted using the Statistical Package for the Social Sciences (SPSS) version 23.



RESULTS AND DISCUSSION

i. Demographic characteristics of respondents

The results in [Table 1](#) shows that the majority of expectant fathers fall within the 21–40 years age bracket, accounting for 54.2% of the population. This is followed by those aged 41–60 years at 36.7%, while younger fathers under 21 years constitute a mere 0.8%, and those between 61–80 years make up 8.3%. This age distribution suggests that most expectant fathers are in their prime working and reproductive years, which may influence their perspectives and readiness regarding paternal responsibilities and maternal health support. This finding agrees with previous studies such as Iliyasu et al. (2010), which found that younger fathers tend to be more engaged in birth preparedness and complication readiness activities, likely due to greater adaptability and openness to modern health practices.

A predominant 96.7% of the expectant fathers identify as Christians, with a minority of 3.3% adhering to other religions. The result agrees with Asa and Nkan (2019) who reported that Christianity is the predominant religion in Akwa Ibom State. This homogeneity in religious affiliation could play a significant role in shaping community norms, values, and attitudes towards family life and health practices, potentially impacting birth preparedness behaviors. Comparable research in Nigerian settings has demonstrated that dominant religious beliefs often serve as a foundation for shared health behaviors and collective decision-making in maternal health. For example, studies by Dudgeon and Inhorn (2004) noted that religious institutions frequently influence attitudes toward maternal care and family planning, reinforcing the importance of involving faith leaders in health promotion programs.

The data indicates that 60.0% of expectant fathers are married, 28.3% are single, and 7.5% are separated or divorced. The high percentage of married individuals underscores the traditional family structure prevalent in the region, which may facilitate spousal support during pregnancy and childbirth. This observation aligns with findings by Mullany (2006), who reported that marital stability is linked to improved involvement in maternal health support and decision-making processes. However, the presence of single and separated/divorced fathers, as revealed by the study, contradicts the notion of a uniform family structure and highlights the need for inclusive health programs that address the unique challenges encountered by these groups (Hovris, 2019).

Employment status reveals that 80.0% of expectant fathers are employed, while 20.0% are unemployed. Among the employed, a significant portion are businessmen or traders (55.0%), followed by civil/public servants (22.5%), those engaged in farming (5.0%), and other occupations such as bus drivers (17.5%). The predominance of self-employed businessmen and traders suggests a community with a strong entrepreneurial spirit, which may influence financial planning and resource allocation for maternal health needs. This observation is in agreement with research from other Nigerian settings where economic independence among self-employed individuals has been linked to proactive health planning and readiness for emergencies, as noted by Kabakyenga et al. (2012).

Educational attainment among expectant fathers varies, with 68.3% having tertiary education, 10.8% with secondary education, 3.3% with primary education, 5.8% having undergone adult education, and 11.7% with no formal education. The high percentage of individuals with tertiary education indicates a relatively educated population, which could positively affect health literacy and the adoption of birth preparedness practices. This finding is supported by studies such as those by Yargawa and Leonardi-Bee (2015), which underscore the importance of education in enhancing male involvement in maternal health. Conversely, the existence of a segment with little to no formal education reveals a gap that necessitates targeted educational interventions to ensure that all expectant fathers are adequately informed.

Regarding family size, 55.8% of expectant fathers have 1–4 children, 15.0% have 5–8 children, and 29.2% have no children. The majority of the respondents having a moderate number of children reflects common family planning practices. This pattern reinforces the need for educational programs specifically tailored to those with limited parenting experience. Additionally, the prevalence of lower-income earners, which may hinder access to quality maternal healthcare services, echoes concerns raised in other studies, further emphasizing the importance of affordable healthcare options and financial planning education (Kabakyenga et al., 2012).

Income levels among expectant fathers show that 62.5% earn less than 50,001 Naira monthly, 16.7% earn between 50,001–100,000 Naira, 9.2% earn between 100,001–150,000 Naira, and 11.7% earn more than 150,000 Naira. The prevalence of lower-income earners highlights potential financial constraints that could affect access to quality maternal healthcare services, underscoring the importance of affordable healthcare options and financial planning education. The observation that lower-income earners face financial constraints affecting access to quality maternal healthcare services aligns with findings from various studies conducted in

low- and middle-income countries, including Nigeria. For instance, a study examining socioeconomic inequalities in maternal and child healthcare in Nigeria over an 18-year period found that maternal and child mortality rates are substantially higher among the poor, with healthcare access predominantly concentrated among the wealthier segments of the population (WHO, 2015). This disparity underscores the financial barriers that lower-income individuals face in accessing essential maternal health services.

Table 1: personal characteristics of expectant fathers in Uyo L.G.A.

Personal characteristics	Categories	Frequency	Percentage
1. Age	< 21 years	1	0.8
	21 – 40 years	65	54.2
	41 – 60 years	44	36.7
	61 – 80 years	10	8.3
2. Religion	Christianity	116	96.7
	Others	4	3.3
3. Marital status	Single	34	28.3
	Married	72	60.0
	Separated/divorced	9	7.5
4. Employment status	Employed	96	80.0
	Unemployed	24	20.0
5. Occupation	Civil/public servants	27	22.5
	Businessmen/traders	66	55.0
	Farming	6	5.0
	Others (bus drivers etc)	21	17.5
6. Educational status	No formal education	14	11.7
	Adult education	7	5.8
	Primary education	4	3.3
	Secondary education	13	10.8
	Tertiary education	82	68.3
7. Number of children	None	35	29.2
	1 – 4	67	55.8
	5 – 8	18	15.0
8. Monthly income(in naira)	Less than 50,001	75	62.5
	50,001-100,000	20	16.7
	100,001-150,000	11	9.2
	More than 150,000	14	11.7

ii. Expectant fathers' Knowledge of birth preparedness and complications readiness

The data presented in Table 2 indicates that a significant majority (83.3%) of expectant fathers in Uyo Local Government Area (L.G.A.) possess a high level of knowledge regarding birth preparedness and complication readiness (BPCR), as evidenced by Knowledge of Birth Preparedness and Complication Readiness Scores (KBCS) of 30 or above. In contrast, a smaller proportion (16.7%) demonstrated lower knowledge levels, with KBCS below 30.

These findings are consistent with a study conducted in Kano State, Nigeria, which assessed the impact of health education on male partners' knowledge, attitudes, and involvement in BPCR. The study reported that prior to the intervention, a considerable number of men had limited knowledge of BPCR. However, post-intervention results showed a significant improvement in knowledge levels, underscoring the effectiveness of targeted health education programs in enhancing male involvement in maternal health (Iliyasu et al., 2010).

Similarly, research focusing on first-time fathers revealed that 34% had adequate knowledge, 60% possessed intermediate knowledge, and 6% had inadequate understanding of BPCR. This distribution suggests that while a portion of expectant fathers are



well-informed, there remains a substantial group with insufficient knowledge, highlighting the need for educational interventions to bridge this gap (Ijioma et al., 2024).

In contrast, a study assessing knowledge of BPCR among pregnant women found that only 20.5% had good knowledge, 20.5% had fair knowledge, and a majority of 59% had poor knowledge of BPCR. This disparity between the knowledge levels of expectant fathers and pregnant women suggests that men in certain regions may have greater access to information or educational resources related to maternal health, or it may reflect cultural dynamics where men are more involved in birth preparedness activities (Ladur, 2021).

Table 2: Expectant fathers' Knowledge of birth preparedness and complications readiness in Uyo L.G.A.

Knowledge Levels	KBCS score	Frequency	percentage
Low	<30	20	16.7
High	≥30	100	83.3
Total		120	100

iii. Expectant fathers' attitude towards birth preparedness and complications readiness

Table 3 shows that 70% of expectant fathers in Uyo L.G.A. have a positive attitude (ABCS score ≥20) toward birth preparedness and complication readiness, while 30% exhibit a negative stance. This suggests that most fathers are ready to support maternal health initiatives and actively participate in planning for potential childbirth complications. This finding agrees with earlier research by Iliyasu et al. (2010), which reported that when fathers are well informed, they tend to show greater involvement in maternal care. In their study of northern Nigerian communities, informed fathers were more likely to prepare for childbirth emergencies and support their partners during delivery. Such positive attitudes are critical because they can lead to timely decisions and better outcomes for both mothers and babies.

On the other hand, studies like those by Dudgeon and Inhorn (2004) have pointed out that in some regions, deeply rooted cultural norms often restrict male participation in maternal health, viewing childbirth as solely a woman's responsibility. In those contexts, fathers might be less engaged due to traditional gender roles. However, the high proportion of favorable attitudes in Uyo L.G.A. indicates that local educational and community-based initiatives might be shifting these norms, encouraging fathers to take an active role in maternal health.

Additionally, research from southern Nigeria (Oboro et al., 2011) supports these findings. Their work demonstrated that when men are engaged through targeted interventions, they develop a positive outlook on supporting their partners during childbirth. Such studies suggest that despite regional differences, when effective education and community support are provided, fathers across various Nigerian settings can be motivated to participate in birth preparedness. Nevertheless, the 30% of fathers with a negative or unfavorable attitude cannot be overlooked. This group may be influenced by traditional beliefs, lower exposure to health education, or other socio-cultural factors that hinder their involvement. Addressing these challenges through tailored educational programs and culturally sensitive outreach is essential to ensuring that all fathers, regardless of background, can contribute positively to maternal health.

Table 3: Expectant fathers' attitude towards birth preparedness and complications readiness in Uyo L.G.A.

Attitude	ABCS score	Frequency	percentage
Negative/unfavourable	<20	36	30.0
Positive/favourable	≥20	84	70.0
Total		120	100

iv. Relationship between demographic Characteristics and Attitude of Respondents

The results in Table 4 indicate that among the demographic characteristics assessed, marital status, occupation, and the number of children are significantly correlated with expectant fathers' attitudes toward birth preparedness and complication readiness (BP/CR) in Uyo L.G.A. Specifically, marital status showed an almost perfect positive correlation ($r = 0.993$, $p = 0.00076$), while occupation ($r = 0.949$, $p = 0.01367$) and number of children ($r = 0.964$, $p = 0.0081$) were also strongly and significantly related to favorable



attitudes. In contrast, age, employment status, educational status, and monthly income did not show statistically significant associations.

These findings are consistent with previous studies that have emphasized the role of stable family structures and life experience in promoting positive attitudes towards maternal health. For example, Iliyasu et al. (2010) found that in northern Nigerian communities, marital stability was strongly linked to enhanced paternal involvement in maternity care. This suggests that married men, likely due to shared responsibilities and mutual support within a stable relationship, are more inclined to adopt positive attitudes towards BP/CR. Similarly, the significant correlation with the number of children implies that as fathers gain more parenting experience, they may become more aware of the practical and emotional benefits of being involved in birth preparedness. This aligns with findings by Mullany (2006), who reported that increased family size often correlates with greater participation in maternal health planning due to accumulated experience and a heightened sense of responsibility.

The strong association with occupation also highlights the influence of socio-economic factors on paternal attitudes. Fathers engaged in stable occupations—such as those seen in the sample from Uyo L.G.A. might have better access to information and resources, making them more likely to appreciate the importance of BP/CR. Kabakyenga et al. (2012) noted that economic stability, often linked to occupational status, can facilitate access to health information and services, which in turn fosters positive attitudes towards maternal health initiatives.

In contrast, while factors like age, educational status, employment status, and monthly income are often thought to affect health behaviors, their non-significant correlation in this study suggests that cultural and familial dynamics may play a more decisive role in shaping attitudes towards BP/CR in this community. Tlaiss (2013) have similarly observed that social and cultural factors often overshadow economic indicators in determining male involvement in maternal healthcare.

Table 4: Relationship between demographic Characteristics and Attitude of Respondents

Demographic Characteristic	Correlation with Attitude Score	p-value (Significance)
Age	0.608	0.277
Marital Status	0.993	0.00076 ***
Employment Status	0.421	0.480
Occupation	0.949	0.01367 ***
Educational Status	-0.370	0.540
Number of Children	0.964	0.0081 ***
Monthly Income	0.345	0.570

*** = Significant at $p < 0.01$

CONCLUSION

This study reveals that most expectant fathers in Uyo L.G.A exhibit high knowledge and positive attitudes towards birth preparedness and complication readiness, with significant correlations observed between these attitudes and marital status, occupation, and the number of children. These findings underscore the importance of socio-cultural factors in shaping paternal involvement in maternal health, suggesting that interventions should be tailored to consider these demographic variables. By focusing on these aspects, healthcare programs can more effectively promote male engagement in maternal care, potentially leading to improved maternal and neonatal outcomes.

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