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Richard Fletcher

Faye Forbes

Abel Fekadu Dadi

Getachew Mullu Kassa

Casey Regan

See next page for additional authors

Authors

Richard Fletcher, Faye Forbes, Abel Fekadu Dadi, Getachew Mullu Kassa, Casey Regan, Anna Galle, Addisu Beyene, Rebecca Liackman, and Marleen Temmerman

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NARRATIVE REVIEW

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Effect of male partners' involvement and support on reproductive, maternal and child health and well-being in East Africa: A scoping review

Richard Fletcher[1] | Faye Forbes[2,3] | Abel Fekadu Dadi[4] | Getachew Mullu Kassa[5] | Casey Regan[1] | Anna Galle[6] | Addisu Beyene[7,8] | Rebecca Liackman[1] | Marleen Temmerman[9,10]

[1]College of Health, Medicine and Wellbeing, The University of Newcastle, Callaghan, New South Wales, Australia

[2]College of Health Sciences, Debre Markos University, Debre Markos, Ethiopia

[3]Global and Women's Health Unit, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia

[4]Menzies School of Health Research, Charles Darwin University, NT, Australia & Addis Continental Institute of Public Health, Addis Ababa, Ethiopia

[5]Johns Hopkins University School of Nursing, Baltimore, Maryland, USA

[6]Department Public Health and Primary Care, International Centre for Reproductive Health, Ghent University, Ghent, Belgium

[7]School of Public Health, College of Health and Medical Sciences, Haramaya University, Harar, Ethiopia

[8]Centre for Women's Health Research, College of Health, Medicine and Wellbeing, University of Newcastle, Newcastle, Australia

[9]Faculty of Medicine and Health Sciences, Ghent University, Ghent, Belgium

[10]Centre of Excellence in Women and Child Health, Aga Khan University, Nairobi, Kenya

Correspondence

Abel Fekadu Dadi, Menzies School of Health Research, Charles Darwin University, NT, Australia & Addis Continental Institute of Public Health, Addis Ababa, Ethiopia.
Email: abel.dadi@menzies.edu.au

Abstract

Background and Aims: East African countries have high rates of maternal and child mortality and morbidity. Studies have shown that the involvement of male partners in reproductive health can benefit maternal and child health (MCH). This scoping review aims to provide an overview of the evidence across East Africa that describes male partner involvement and its effect on maternal, reproductive, and child well-being.

Methods: Ten databases were searched to identify quantitative data on male's involvement in East Africa. Studies reporting qualitative data, "intention to use" data or only reporting on male partner's education or economic status were excluded. Studies were organized into five a priori categories: antenatal care (ANC), human immunodeficiency virus, breastfeeding, family planning, and intimate partner violence with further categories developed based on studies included.

Results: A total of 2787 records were identified; 644 full texts were reviewed, and 96 studies were included in this review. Data were reported on 118,967 mothers/pregnant women and 15,361 male partners. Most of the studies ($n = 83$) were reported from four countries Ethiopia ($n = 49$), Kenya ($n = 14$), Tanzania ($n = 12$) and Uganda ($n = 10$). The evidence indicates that male partner involvement and support is associated with improved reproductive, MCH across a wide range of outcomes. However, the studies were heterogeneous, using diverse exposure and outcome measures. Also, male partners' lack of practical and emotional support, and engagement in violent behaviors towards partners, were associated with profound negative impacts on MCH and well-being.

Conclusions: The body of evidence, although heterogeneous, provides compelling support for male involvement in reproductive health programs designed to support MCH. To advance research in this field, an agreement is needed on a measure of male partner "involvement." To optimize benefits of male partners' involvement, developing core outcome sets and regional coordination are recommended.

KEYWORDS
child health, East Africa, male partner involvement, maternal health, reproductive health care

1 | INTRODUCTION

In 2017, sub-Saharan African countries alone accounted for two-thirds of the estimated global maternal deaths[1] and a child born in a sub-Saharan African country is 10 times more likely to die in their first month of life, compared to a child born in a high-income country.[2] In sub-Saharan countries, high rates of health-related problems and unmet health care needs frequently result in elevated rates of maternal morbidities such as haemorrhage, infection, hypertensive disorders, and uterine ruptures.[3] High human immunodeficiency virus (HIV) infection rates and mother-to-child-transmissions (MTCT),[4] inadequate nutrition/breastfeeding[5] and intimate partner violence (IPV)[6] affect both the mother's and child's health.[7,8] The Sustainable Development Goal (SDG) to "Ensure healthy lives and promote well-being for all at all ages" aims to end preventable deaths of newborns and children under 5 years of age and reduce the global maternal mortality ratio to less than 70 per 100,000 live births.[9] Although maternal mortality in sub-Saharan countries has decreased over recent decades rates remain at over 500 deaths per 100,000 live births.[10]

Maternal and newborn health (MNH) in East Africa has generally been viewed as exclusively a woman's responsibility within a women's health framework, which limits male participation due to cultural norms that see the involvement of mothers-in-law and other family members as essential.[11] As well, various cultural traditions limit women's involvement in decision making, and position male partners as decision-makers for all aspects of family life while removing them from knowledge of and involvement with maternal and newborn care.[11] Involving male partners in reproductive health can have significant benefits for MNH, particularly in low- and middle-income country settings.[11] The World Health Organization (WHO) has recommended involving fathers, stating that next to improving health care, "The inclusion of fathers is important as they can play a role as caregivers to the newborn and as a source of support for the mother."[12]

Over the last decades, studies from numerous African regions have confirmed that male partner involvement has the potential to influence health outcomes directly, and can also indirectly improve MNH by increasing couple communication and joint decision making.[13] A partner providing significant emotional,[14] practical[15] and financial[16] support has been found to reduce barriers for women to access health services and can normalize women's care-seeking behaviors.[17] For example, women are more likely to use antenatal (ANC) and postnatal care (PNC) facilities, accept medical tests and counseling and seek skilled birth attendants (SBAs) when their partners are supportive.[17–19] Other areas in which male partner emotional and material support are beneficial are family planning, HIV care, breastfeeding practices and child nutrition and maternal health.[19–21]

Systematic reviews examining male partner involvement in reproductive health care include numerous studies reporting a positive association between men's active engagement in the pregnancy, birth and postnatal period in low and middle income countries settings.[22–24] However, there are three features of this body of evidence that limit its usefulness for designing interventions and policies to address maternal and infant health in East African countries: the body of evidence is fragmented in geography, focused on specific health conditions or behaviors, and male partner involvement is poorly defined. This scoping review aims to support a more integrated approach to increasing partner support for mothers and infants in East African countries by identifying the geographic spread, health outcome, and male partner involvement measures among studies demonstrating a link between male partner involvement and maternal and child well-being.

2 | METHODS

This scoping review was informed by the Joanna Briggs Institute Reviewers' Manual 2015.[25] A scoping review aims to identify literature relating to a broad research topic and map the findings to inform key concepts, theories, sources of evidence, and research gaps.[26,27]

2.1 | Eligibility criteria

We included all research articles written in English, including pilot studies, randomized and non-randomized controlled trials and pre- and post-test designs. Literature reviews, qualitative studies, case studies, study protocols, dissertations, studies with participants (as parents) younger than 12 years or with data restricted to male partners' level of education, income, or their absence from home, and conference abstracts were ineligible. Only studies reporting at least one outcome measure related to maternal and/or infant outcomes from conception to infant age 2 years were included, however "intention to use" outcomes were excluded. Studies involving "ever-pregnant" women and reported on male partners' beliefs, knowledge, attitudes, or behaviors about their partner's and/or infant's health were included. The United Nations "Standard Country or Area Codes for Statistical Use"[28] was used to determine countries or territories considered "East African." Additionally, systematic reviews were retrieved from the search and screened for eligible studies. Those studies reporting male partner involvement and mother, or infant outcomes were identified and screened full text by two reviewers using the eligibility criteria.

2.2 | Search strategy

Ten databases were used to search for literature (Medline, Scopus, EMBASE, Emcare, POPLINE, EBSCO, PsychINFO, Maternity and

Infant Care, CINAHL and African Index Medicus) by multiple authors on September 24, 2018 and updated on July 15, 2021 July 15, 2020. The following is an example of the search terms used for Scopus: (TITLE-ABS-KEY ((pregnan* OR maternal OR antenatal OR prenatal OR newborn OR infant OR breastfeed* OR "breastfeed*" OR "family health" OR "womens health" OR perinatal OR infant* OR child* OR baby* OR babies* OR mother*)) AND TITLE-ABS-KEY (((dad OR dads OR paternal OR father* OR husband* OR "male partner*" Or spouse*) AND (belief* OR attitude* OR knowledge OR behavior* OR behavior* OR engag* OR involve*))) AND TITLE-ABS-KEY (("east* africa*" OR "british Indian ocean" OR "french southern territor* OR "south sudan" OR Burundi* OR comoros* OR djibout* OR Eritrea* OR Ethiopia* OR Kenya* OR madagasca* OR Malawi* OR mauriti* OR mayotte* OR mozambiqu* OR reunion* OR Rwanda* OR seychell* OR Somalia* OR Uganda* OR Tanzania* OR Zambia* OR Zimbabwe*))). We imported all references retrieved from the searches into Covidence, an online software for managing systematic reviews.[29]

2.3 | Study selection process and outcome definition

In Covidence, all records were screened for relevance by two authors using the eligibility criteria. All listed authors independently screened the abstracts, with conflicts resolved by a third reviewer. Two reviewers (R. F., B. S., R. L., C. R., or N. V.) independently screened the full text of studies with conflicts resolved by a third reviewer (Figure 1). The perinatal outcomes and conclusions reported in this scoping review are framed by recommendations or guidelines specifying treatment regimens or behaviors set by authoritative national or international bodies (Table 1).

2.4 | Data extraction and synthesis of results

The data were extracted into an Excel spreadsheet by R. F., B. S., C. R., and N. V. Recorded data included author, year of publication, country, participant information, study aims, design and data collection, outcomes and results. Several outcomes were expected and proposed before commencing and others emerged following discussion during data extractions. The final list of outcomes is as follows: (1) ANC, (2) Childbirth, (3) HIV care, (4) Breastfeeding, (5) Child health, (6) Family planning (7) Maternal health and (8) IPV. Data for each outcome was collated and evidence tables were developed to present each topic separately.

3 | RESULTS

A database search in September 2018 identified 2323 articles; a further database search in July 2020 identified another 347. Forty-four systematic reviews identified 171 articles. After the exclusion of

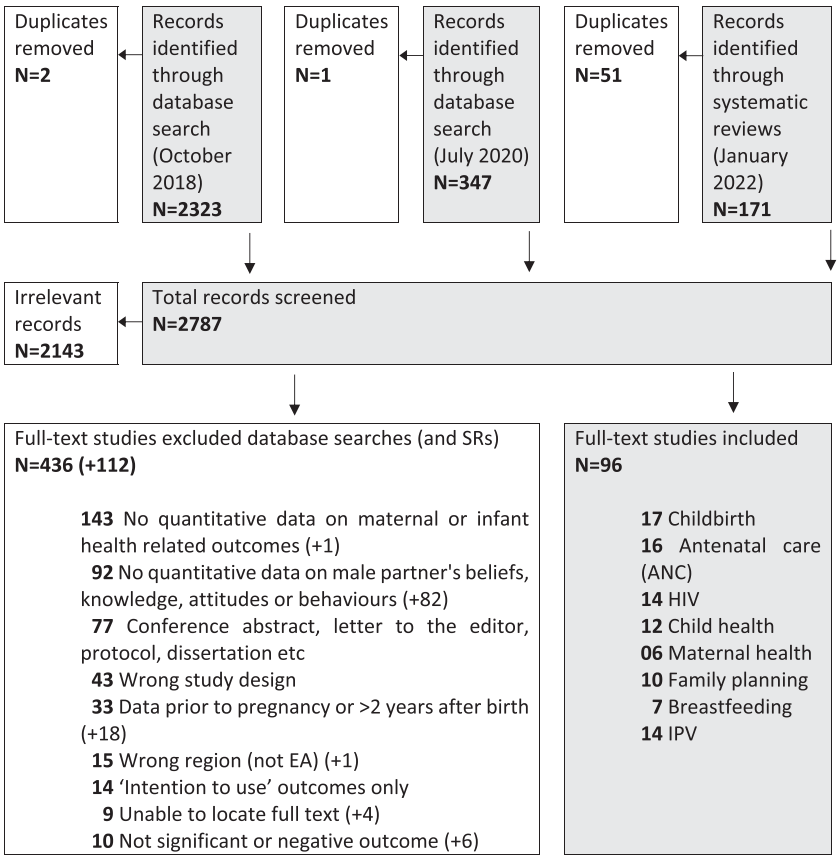

FIGURE 1 Flowchart of studies through review of male partner involvement and its impacts on maternal and child well-being.

TABLE 1 Guidelines for maternal and infant health outcomes.

Outcomes	Guidelines
ANC	The WHO recommends a minimum of eight ANC contacts for women throughout their pregnancy,[30] some countries have adopted the 4-visit model.[31]
Childbirth	A skilled birth attendant is a skilled health professional present during labor and birth.[32]
HIV	Outcomes related to the human immunodeficiency virus (HIV) include a husband's attitude towards a mother's positive HIV status, the likelihood of the father and/or mother being tested, mothers using and adhering to HIV medication and mother-to-child transmission (MTCT) of HIV. The WHO has recommended "Option B+" for the prevention of MTCT and sexual transmissions since 2012, which is a program offering medication to women from first identification as HIV positive and continuing the rest of their lives.[33]
Breastfeeding	Exclusive breastfeeding (EBF) is globally recommended for an infant's first 6 months of life[34] and also for HIV positive mothers. The WHO states that mothers living with HIV should breastfeed at least 6 months while being treated with antiretroviral medication.[35] While there are risks of HIV transmission through breastfeeding, inappropriate or inadequate foods and drinks risks malnutrition, diarrhoea and pneumonia.[36]
Family planning	Preventing unplanned pregnancies is a vital component of the WHO's strategy in preventing MTCT.[37] Modern contraceptive methods are recommended to avoid short birth-spacing (i.e. under 18 months) which is associated with higher risks of maternal and infant mortality and complications.[38]
Child health	A child's health is commonly measured using height and weight for age (i.e. Weight for Height in children [WHZ] and Height for Age in children [HAZ]). Additionally, a diverse diet that includes all food groups is considered a good indication of a child's nutritional status and health.[39] "Child mortality" refers to mortality of children under the age of five is indicated.[40]
Maternal health	Outcomes in maternal health include mortality,[10] morbidities,[41] smoking and alcohol consumption,[42] low birthweight, preterm birth and stillbirth.[43–45]
IPV	Many incidents of violence against women involve their male intimate partners, or ex-partners.[46] Intimate partner violence (IPV) includes physical abuse, and/or sexual abuse and/or emotional/psychological abuse.

Abbreviations: ANC, antenatal care; WHO, World Health Organization.

duplicates and screening on title and abstract, full-text screening was undertaken on 644 papers. (Figure 1). Thirteen papers identified in the searches were excluded as they were unable to be accessed for screening. Continued screening during extraction resulted in 96 papers identified as eligible for inclusion. A full list of included studies, by primary topic and country, is provided in Table 2.

3.1 | Study characteristics

Many of the studies originated from Ethiopia ($n = 49$), Kenya ($n = 14$), Tanzania ($n = 12$) and Uganda ($n = 10$). The remaining studies were from Malawi ($n = 4$), Zambia ($n = 2$), Mozambique ($n = 2$), Rwanda ($n = 3$), Zimbabwe ($n = 1$), and Somaliland ($n = 1$) although one study (118) included data from Burundi, Rwanda, Tanzania, Uganda and Kenya. Most of the studies ($n = 93/96$) used surveys administered by an interviewer to collect quantitative data. Mothers were the primary participants of the included studies and data were collected from a total of 118,967 mothers/pregnant women and 15,361 fathers/male partners (Table 2). Data on fathers and male partners were typically collected by the mothers/female partners reporting on the father's/male partner's involvement.

Six categories were identified by grouping specific factors of male partner behaviors, knowledge or attitudes within the outcome categories across the 96 studies included in the scoping review: presence; attitudes; partner communication (i.e., joint decision making or discussion); health behaviors and knowledge; sexual and reproductive intentions; and IPV (Table 1 Supporting Information). Below we describe findings for each topic, mapped against these categories of male partner behaviors, knowledge, and attitudes. Supporting Information S1: Table 2-5 Supporting Information details the country, participants, design, aim, and results for each study.

3.2 | Impact of male partner involvement on ANC and childbirth

Male partner involvement was measured as financial support, attitudes (or acceptance/approval) toward ANC, presence (including accompaniment to ANC visits and involvement in hard labor tasks, and joint decision making). Several studies showed a strong association between male partner involvement and ANC service uptake.[47–61] (Supporting Information S1: Table 2 Supporting Information) For example, women receiving financial support from their male partner were more likely to use ANC than those who did not.[47] Women whose male partners expressed positive attitudes or acceptance/approval towards ANC were 3.5–9 times more likely to utilize ANC[49–51] and more likely to complete four ANC visits[52,53,62] compared to women whose partners perceived ANC negatively. Male partner accompaniment of women to ANC visits was associated with a higher uptake of ANC visits.[54] Conversely, women who attended ANC without their male partner were nearly seven times more likely

TABLE 2 Number of studies per topic, participant status, and countries.

Topic	Number of studies	Participants		Countries
		Mothers/pregnant women	Fathers/male partner	
Antenatal care	16	19,812	8264	Ethiopia, Kenya, Mozambique, Tanzania,
Childbirth	17	17,008	1556	Ethiopia, Kenya, Malawi, Tanzania, Uganda, Zambia
Human immunodeficiency virus	14	23,816	-	Ethiopia, Kenya, Malawi, Tanzania, Uganda, Zimbabwe
Breastfeeding	7	2856	-	Ethiopia, Somaliland, Uganda
Child Health	12	9260	3936	Ethiopia, Kenya, Rwanda
Family Planning	10	9316	1000	Ethiopia, Kenya, Malawi, Rwanda, Tanzania, Uganda
Maternal Health	16	4161	-	Ethiopia, Uganda
Intimate Partner Violence	14	32,738	605	Burundi, Ethiopia, Kenya, Rwanda, Tanzania, Uganda, Zambia
Total	96	118,967	15,361	

to delay the commencement of ANC.[57] Women were more likely to utilize ANC services if they decided together with their husbands on ANC services or household purchases.[60] Increased male partner involvement assessed across multiple supportive behaviors related to maternal health services was associated with a greater likelihood of timely initiation of ANC.[61]

Sixteen studies explored how male partner involvement can positively or negatively influence SBA and/or childbirth at a health facility.[18,63–78] (Supporting Information S1: Table 2) Male partner involvement was measured as an accompaniment to ANC visits, attitudes (or acceptance/approval) toward childbirth health care, and involvement in decision making and discussion. Women who were accompanied by their partners to ANC visits were more likely to have skilled birth attendance[18,63] and deliver at a health facility[64] compared to women who were not accompanied by their partners. Women whose male partner preferred home childbirth were more likely to deliver at home,[65] and women whose male partner expressed positive attitudes towards ANC were more likely to give birth in health facilities.[66] Women with a male partner who was involved in decision making regarding childbirth place were 1.9–6.8 times more likely to deliver at a health facility[69–73] compared to women making decisions on their own.

3.3 | Impact of male partner involvement on breastfeeding and HIV care

Male partner involvement in breastfeeding primarily consists of support, which is linked to exclusive breastfeeding and timely initiation of complementary feeding. Several studies report a positive impact of partner support on child nutrition indicators.[79–85] (Supporting Information S1: Table 3) For example, mothers with husbands who were supportive of breastfeeding were 2.3–4.9 more likely to exclusively breastfeed compared to those who did not get their father's support.[79–82] Mothers with husband support during child feeding were more likely to initiate complementary feeding at an appropriate time compared to those without husband support.[83] Conversely, women who did not get support from their husbands to exclusively breastfeed were 68%–74% less likely to have good practices in exclusive breastfeeding.[84,85]

Male partner impact on HIV care included presence/involvement (attendance in couple HIV testing, counseling and PMTCT activities), attitudes (or acceptance/approval) toward family planning and IPV, communication (joint decision making and spousal discussion), and health behaviors (alcohol consumption). Several studies reported that such factors were found to impact nevirapine uptake, ART treatment adherence, PMTCT continuum adherence, condom use, facility-based childbirth, receive HIV test results, HIV self-testing, postpartum HIV status, infant HIV acquisition through MTCT, MTCT knowledge and uptake of family planning.[16,86–97] (Supporting Information S1: Table 3) For example, women with partners who were involved in HIV testing, counseling or other PMTCT activities were more likely to: return for follow-up to receive nevirapine[86]; take maternal or infant dose of nevirapine[86]; adhere to Option B plus ART treatment[87]; successfully complete all steps in the PMTCT continuum[88]; and, show improved retention in HIV care.[89] Postpartum women with a partner who ever refused the use of a condom were more likely to have a positive HIV status (Adjusted Odds Ratio = 1.88; 95% confidence interval 1.20, 2.90) compared to women with a partner who never refused.[94]

3.4 | Impact of male partner involvement on family planning, maternal and child health (MCH)

Male partner involvement in family planning included ANC attendance, approval or support toward contraceptive use, spousal discussion and joint decision making, and reproductive intentions. Such factors were found to have an impact on family planning service uptake and maternal intention for more children.[98–107] For example, women with partners involved in a discussion about contraceptive use were more likely to initiate postpartum contraceptive utilization on time,[104] utilize family planning services,[105] use contraceptives since childbirth,[105] and were less likely to discontinue contraceptive use[102] compared to those who have never discussed contraception with their partners. Furthermore, HIV positive women with a partner who desired more children were also more likely to intend to have more children.[107]

Male partner involvement in the child's health is demonstrated by his: presence (including childcare activities, infant feeding, and ANC attendance); positive attitudes and support; communication (joint decision making); and health knowledge was shown to impact the child's dietary diversity and complementary feeding, development, HIV infection, and vaccination status. Several studies reported better health outcomes for children in families having supportive partner.[108–118] (Supporting Information S1: Table 4) For example, infants born to women with poor partner ANC attendance had an increased risk of death or infection due to HIV compared to those born to women with partner attendance.[113] One study that assessed urban and rural families separately found that among both types, children whose fathers had good knowledge of keeping the child healthy, food groups, and childcare were 2.9–8.4 times more likely to meet the minimum dietary diversity compared to those with poor knowledge.[108]

Male partner involvement in maternal health was measured as involvement and support during pregnancy, which was found to have an impact on birth preparedness and antenatal depression.[119–122] (Supporting Information S1: Table 4) For example, women with husbands who accompanied them to the place of childbirth were more likely to report good birth preparedness[119] compared to women with husbands who did not accompany them. Also, women whose partners were unsupportive and uninvolved during pregnancy were more likely to demonstrate clinically significant symptoms of antenatal depression[120] compared to women with involved and supportive partners during pregnancy.

3.5 | Impact of IPV on maternal and infant outcomes

IPV was found to be associated with several maternal and infant outcomes including depression, exclusive breastfeeding, health facility utilization (including ANC), HIV testing, maternal alcohol consumption, pregnancy loss and infant mortality.[6,123–137] (Supporting Information S1: Table 5) For example, women who were physically abused by their partner were less likely to (i) deliver in a health facility; (ii) get HIV testing; (iii) use a skilled delivery attendant; (iv) attend four or more ANC visits[130]; (v) to seek treatment for child's diarrhoea and ARI[133]; (vi) to have unplanned pregnancy,[135] (vii) repeat-induced abortion,[136] and (viii) pregnancy loss[137] and infant mortality.[6]

4 | DISCUSSION

As part of a global effort to reduce maternal and infant mortality and morbidity, there has been a focus on interventions in the perinatal period. In East Africa, where poor maternal and infant health outcomes are prevalent, gender inequality is widely recognized as a major contributing factor.[138] Consequently, there has been increasing interest in the role of male partners in supporting maternal physical and mental health and improving infant well-being. This review shows that a partner's attitudes, knowledge, and behaviors are crucial for a woman's well-being and that of her infant throughout her journey from conception, through pregnancy and birth, to infant feeding and care. Although mothers are often the focus of health services and public health interventions, a partner's involvement can enhance or impair her access and engagement which will, in turn, affect the health and well-being of their children. The partner's support can include his attitudes, to HIV testing for example, or his behaviors such as providing transport or accompanying the mother to the clinic. Partner engagement, in couple counseling or discussing family planning, can reduce health risks while violence to the mother can directly impair her well-being as well as prevent her from accessing health services.

A limitation in the evidence is that studies are typically confined to a particular aspect of maternal or infant health thereby hindering the development of family-based interventions which address the range of conditions and causal factors impinging on health outcomes. This scoping review is a critical first step in conceptualizing an approach to maternal and infant health in the perinatal period that is inclusive of male partners across health conditions. While it is accepted that the evidence presented in this review is variable in the design and method of data collection, the demonstrated link between male partner's involvement and improved reproductive, mother and infant outcomes support efforts to include male partners to meet the SDG for maternal and infant health. Studies in each topic area demonstrate the potential for improved family health by engaging male partners.

Researchers authoring many of the studies included in this review add their voices to the call from international and national bodies for more efforts to involve male partners in every aspect of reproductive health.[12,139] However, achieving significant change in this area has proved to be elusive. Several reviews have documented successful strategies for increasing male partner involvement, some reported decades ago[16,23,140] yet initiatives remain small-scale and reliant on research or NGO funding. While assessing strategies for improving male partner involvement was not the purpose of this review, several points can be drawn from the data which may assist in developing more comprehensive and sustainable change.

Many counties within the East African region currently lack data on male partner involvement to guide their approach to improving maternal and infant health—despite an abundance of such studies being conducted. In this review Ethiopia, Kenya, Tanzania, and Uganda were the most frequently studied populations. While 11 countries were represented in the evidence base there were no studies from half of the 22 East African countries. However, all countries in this region face similar serious situations where rates of maternal and infant mortality and morbidity are unacceptably high. As well as improving co-operation between stakeholders within countries,[141] a regional approach to sharing research evidence and intervention planning would avoid the potentially long time delay while studies from those countries without evidence replicate what is already well established in Ethiopian, Ugandan and Tanzanian studies. Such an approach would build on existing regional co-ordination mechanisms, such as the East Africa Community linking countries across the region undertaking joint action towards the prevention and control of communicable and noncommunicable diseases,[142] as well as previous initiatives trialing interventions to include male partners in reproductive health involving several East African countries.[143]

There are also lessons to be drawn from this review for designing future research to support male partner involvement in the perinatal period. Developing interventions that take a continuum of care approach to support men's engagement may be key to moving forward. For example, investigations of male partner involvement in addressing health conditions such as HIV have targeted male partner behaviors and attitudes that might also impact other important conditions. A male partner who encourages his partner to attend antenatal clinics with her and willingly undertakes couple counseling and HIV testing is also likely to be supportive of early ANC and may be more receptive to information describing the possible benefits of breastfeeding or dietary diversity for their infant. Theoretical frameworks for broadening health promotion and service perspectives may offer a template for supporting inclusive approaches to male partner involvement.[144,145]

Developing more rigorous methods for assessing the impact of male partners' beliefs and behaviors may also improve future research and interventions. The outcome measures for MCH across the wide range of conditions reported in this review were diverse and within topic areas data collection methods varied considerably. Male partners' positive engagement with pregnancy, birth and PNC was captured under the rubric of "male partner involvement." For some studies a male partner accompanying the mother to a clinic qualified as involvement. For others, a male partner needed to provide emotional and practical support and be willing to share decision making on key health choices such as birth location, contraception, HIV assessment and treatment to be judged as involved.

Developing an agreed-upon tool for measuring male partner involvement may go some way to address this need. The "male involvement index"[146] has shown to be useful for specifically assessing male involvement in HIV interventions, involving two factors, communication-based involvement and action-based involvement. More recently a global framework was developed by Galle et al.[147] consisting of five categories for assessing male involvement comprehensively: involvement in communication, involvement in decision making, practical involvement, physical involvement and emotional involvement. The latter instrument will need further refinement depending on the context but may well be useful for comparing studies and interventions across the maternal and infant health field. Improving the measurement of male partner behaviors, however, may not address the concerns of those who see increasing women's autonomy and share in decision making as critical to improving maternal and infant health outcomes.[148,149] Reports linking male partner involvement in perinatal health services and reduced women's autonomy have prompted calls for interventions to explicitly seek to reduce inequalities between men and women and to examine men's and women's subjective experiences of partner relationships following male partner involvement interventions.[150–153] In addition, the role of others, such as mothers-in-law, who may influence male partners' participation in caring roles, and the health system itself should be examined.[154,155] And for some conditions, such as birth complications, a husband's knowledge may be critical.[156]

4.1 | Limitations

This review presents an overview of the literature from East African countries about male partner involvement and maternal and infant outcomes. However, we could not access the full text of a small number of articles, studies not in English were excluded and we did not include studies that reported qualitative data that may have been relevant to our findings. Furthermore, following the scoping review methodology,[26] quality assessment of the included studies was not included. Most reviewed articles featured mothers as participants, with fathers' data often reported by their partners. Thus, the findings predominantly reflect mothers' perspectives. Men's views on their role in reproductive and MCH may differ, seeing themselves primarily as financial providers, in line with societal expectations.

5 | CONCLUSION

Finding avenues to lower the rates of mortality and morbidity of mothers and infants in East Africa is an international imperative. However, the evidence base for interventions must be grounded in research from the region. This scoping review presents an overview of health conditions where male partner involvement can make a significant improvement. The level of evidence, although uneven, provides a compelling case for male partner involvement interventions across a continuum of reproductive health care with attention to measurement of "involvement" and the possibility of regional coordination to maximize impact. To enhance MCH outcomes in East African countries, it is crucial to actively promote male involvement in health strategies. Policymakers and health care providers should develop and implement initiatives that engage men not only as supporters but also as active participants in MCH. This includes creating culturally sensitive

educational programs that redefine gender roles and emphasize the importance of shared responsibility in reproductive health. Additionally, community outreach and communication campaigns should be tailored to overcome traditional views that limit male participation, thereby fostering a more inclusive approach to MCH.

AUTHOR CONTRIBUTIONS

Richard Fletcher: Conceptualization; methodology; data curation; writing—review and editing; writing—original draft; project administration. **Faye Forbes**: Conceptualization; methodology; data curation; writing—review and editing; writing—original draft; project administration. **Abel Fekadu Dadi**: Methodology; data curation; writing—review and editing and corresponded the study. **Getachew Mullu Kassa**: Methodology; data curation; writing—review and editing. **Casey Regan**: Conceptualization; methodology; data curation; writing—review and editing; writing—original draft; project administration. **Anna Galle**: Conceptualization; methodology; data curation; writing—review and editing; writing—original draft; project administration. **Addisu Beyene:** Methodology; data curation; writing—review and editing. **Rebecca Liackman**: Conceptualization; methodology; data curation; writing—review and editing; writing—original draft; project administration. **Marleen Temmerman**: Conceptualization; methodology; data curation; writing—review and editing; writing—original draft; project administration. All authors have read and approved the final version of the manuscript. Richard Fletcher had full access to all the data in this study and takes complete responsibility for the integrity of the data and the accuracy of the data analysis.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

This is a scoping review where all included studies with their data can be accessed online or are included in the main manuscript or supplementary information. However, any other required documents and summary materials can be accessed from the first author upon reasonable request.

TRANSPARENCY STATEMENT

The lead author Abel Fekadu Dadi affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

ORCID

Abel Fekadu Dadi http://orcid.org/0000-0001-9967-7713

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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