

Knowledge, Attitude, and Practice of Midwives of Beni Health Zone Regarding Partners' Participation in Sexual and Reproductive Health Services

Kambale Muholu Jonas^{1*}; Kabange Mulume Nicole²; Kasereka Masimengo Delvis¹; Amuda Baba Dieu-Merci³

¹Lecturer at Higher Institute of Medical Techniques of Beni (ISTM-Beni), DR Congo

²Independent Researcher

³Associate Professor at Higher Institute of Medical Techniques of Bunia (ISTM-Bunia), DR Congo

Corresponding Author : Kambale Muholu Jonas^{1*}

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Abstract:

➤ Introduction

Sexual and reproductive health (SRH) is a crucial element of human well-being, encompassing the rights, services, and care related to sexuality, reproduction, and the health of individuals. This study was conducted to assess the knowledge, attitudes, and practices of midwives in the Beni health zone regarding partner involvement in sexual and reproductive health services.

➤ Methodology

This study was conducted in the Beni health zone, in the north of North Kivu province. A sample of 76 midwives was selected using random sampling. Data were collected using a questionnaire in Kobocollect. The analysis was performed using SPSS software.

➤ Results

The majority of midwives (97.4%) had received training on partner involvement. Many recognize the benefits of this involvement, including better communication and increased emotional support. The majority of respondents are neutral about the importance of involving partners to improve maternal health outcomes. Midwives' practices vary, with particular challenges in rural areas and conflict zones.

➤ Conclusion

Although most midwives recognize the benefits of involving partners, there are still some challenges related to midwives' attitudes and practices. Continuing education programs, supportive policies, and awareness campaigns are needed to improve partner involvement in SRH services.

Keywords: Knowledge, Attitudes, Practices, Midwives, Sexual Partners, Sexual And Reproductive Health Services.

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I. INTRODUCTION

Sexual and reproductive health (SRH) is a fundamental aspect of human well-being that includes rights, services, and

care related to sexuality, reproduction, and the health of individuals (World Health Organization, 2021). It encompasses not only disease prevention, but also the promotion of healthy practices and respect for reproductive

rights (World Health Organization, 2021). SRH plays a crucial role in sustainable development and reducing health inequalities, as it addresses fundamental issues such as access to sex education, family planning, and maternal care (Fun, 2020).

Sexual and reproductive health services are a range of care services designed to help people stay healthy in terms of their sexuality and reproduction (OMS, 2017). This includes aspects such as family planning, care before and after the birth of a baby, treatment and prevention of sexually transmitted diseases, safe abortions, and sex education (OMS, 2017). Sexual and reproductive health services help individuals stay healthy and make informed decisions about their sexual lives and families.

Globally, partner involvement in SRH services is a major issue, but it is often hampered by inequalities in resources, access to education, and public health policies, midwives' knowledge of the benefits of partner involvement, and their practices (Smith, 2022). Midwives' knowledge about the importance of partner involvement may vary across regions. In high-income countries, midwives may have easier access to specialized training and up-to-date information, while in low- and middle-income countries, access to continuing education may be limited (Smith, 2022).

In America, midwives generally have access to better resources and training, but disparities between developed and developing countries influence practices and attitudes (O'Brien, 2021).

In Europe, midwives' knowledge of partner involvement in sexual and reproductive health (SRH) services is generally high in Western countries, where continuing education programs and educational resources are widely available. In contrast, in some Eastern countries, midwives may have limited access to such training, which may affect their understanding and capacity (Smith, 2022). Countries such as France, Germany, and Scandinavian countries have more advanced practices in terms of partner involvement, supported by inclusive public health policies and specialized training for midwives (Smith, 2022).

In Asia, partner involvement in sexual and reproductive health services is an essential aspect of improving care and health outcomes. However, midwives' knowledge, attitudes, and practices in this regard vary significantly due to different contexts. Midwives' knowledge about partner involvement in SRH services in Asia is often influenced by access to training and resources. In developed countries in the region, such as Japan and South Korea, midwives generally have access to high-quality education and up-to-date resources, which improves their understanding of the benefits of partner involvement (Chen, 2019).

However, in some developing countries, such as Bangladesh and Nepal, limited access to continuing education restricts midwives' knowledge and their ability to integrate. Midwives' practices regarding partner involvement in SRH services vary widely across Asia. In countries such as Japan

and South Korea, practices are well established and supported by favorable public health policies (Lee, 2020). However, in countries such as India and the Philippines, practices are more heterogeneous and often influenced by economic constraints, local traditions, and challenges related to access to postnatal care (Ali, 2021).

In Africa, partner involvement in sexual and reproductive health services is crucial to improving health outcomes and promoting balanced relationships. However, midwives' knowledge, attitudes, and practices vary considerably across the continent due to diverse socioeconomic, cultural, and political contexts. These variations influence how partners are integrated into SRH services, with significant implications for the quality of care. (Tawfik, 2022)

Midwives' practices regarding partner involvement in SRH services vary widely across Africa. In countries such as South Africa and Kenya, practices are more advanced and supported by public health policies that promote partner inclusion (Tawfik, 2022). However, in countries such as Niger and the Democratic Republic of Congo (DRC), practices are less developed due to economic constraints, challenges related to access to healthcare, and traditional practices, according to (Mwamba, 2023).

South Africa reported that midwives generally have better resources and more advanced training, which promotes more inclusive practices in terms of partner involvement (Tawfik, 2022).

In Cameroon, partner involvement in sexual and reproductive health services is essential to improving the quality of care and promoting balanced relationships. However, midwives' knowledge, attitudes, and practices regarding partner involvement in these services vary due to specific local challenges, including economic and other constraints. Cameroonian midwives' knowledge of partner involvement in SRH services is uneven, often influenced by varying access to continuing education and educational resources. However, some midwives may benefit from specialized training and appropriate resources. Midwives' practices regarding partner involvement in SRH services in Cameroon vary and may be influenced by economic constraints and challenges related to access to care. In large cities such as Douala and Yaoundé, practices are more developed thanks to better resources and infrastructure. However, in rural or remote areas, practices are less systematic due to limitations in training and support (Ngam, 2022). Midwives also face challenges in integrating partners due to financial constraints and local priorities. Midwives in these urban areas (Douala, Yaoundé) have better access to training and resources, which can promote more inclusive practices in terms of partner involvement (Ngam, 2022).

In the Democratic Republic of Congo (DRC), midwives' knowledge, attitudes, and practices regarding partner involvement vary considerably due to several local challenges, including economic constraints, difficulties in accessing training, and cultural traditions. These factors

influence the quality of sexual and reproductive health services (Mwamba, 2023).

Midwives' practices regarding partner involvement in SRH services vary significantly across the DRC. In urban areas, such as Kinshasa, practices are more advanced thanks to better infrastructure and training programs. However, in rural areas and conflict zones, practices are limited by economic constraints, challenges in accessing care, and inadequate infrastructure (Mwamba, 2023). In urban areas such as Kinshasa and Lubumbashi, midwives generally have better access to resources, continuing education, and infrastructure, which promotes more inclusive practices in terms of partner participation (Mwamba, 2023).

In North Kivu, midwives' knowledge, attitudes, and practices regarding partner involvement are influenced by a complex set of local challenges, including difficult socioeconomic conditions, recurrent armed conflict, and cultural traditions. In Goma, midwives may have better access to resources and training, enabling them to implement more advanced practices in terms of partner involvement (Koffi, 2021).

In Beni, according to the 2022 Health Zone report, male participation in prenatal consultations in Beni is around 10-12%. The constant presence of conflict and insecurity reduces access to health services and often discourages men from accompanying their partners. In family planning, men's participation in family planning discussions and decisions is slightly higher, at around 15-18%. Awareness campaigns by local organizations have some impact despite logistical challenges. In the case of sexually transmitted infection (STI) prevention, approximately 10% of men actively participate in STI prevention programs, including awareness-raising and

screening. Efforts to improve these rates face obstacles related to stigma and misinformation.

The aim of this study is to determine midwives' knowledge, attitudes, and practices regarding partner involvement in Sexual and Reproductive Health services.

II. MATERIAL ET METHODS

This study took place in the Beni Health Zone, in the city of Beni, in the north of North Kivu Province. The Beni Health Zone comprises 22 health areas, including Boikene, Bundji, Butsili, Butanuka, Kanzulinzuli, Kasabinyole, Kasanga, Kuka, Mabakanga, Mabolio, Madrandele, Malepe, Mangothe, Mukulya, Ngilinga, Ngongolio, Paida, Rwangoma, Sayo, Supa, Tamende, and Tuungane, including 16 supported health centers, two health posts, one general referral hospital, and three hospital centers, for a total of 24 healthcare facilities including 16 supported health centers, two health posts, one general referral hospital, and three hospital centers, for a total of 24 integrated healthcare facilities. In addition, there are 217 private healthcare facilities and five community healthcare sites.

This study is descriptive in nature. The sample consisted of all registered midwives working in the Beni health zone. The survey covered 76 midwives who were available during our visit. Sampling was used to construct the sample. The survey questionnaire under Kobocollect was used as a data collection tool. The analysis was performed using SPSS version 20 software, with the numerical data presented in the form of frequency tables obtained by calculating percentages. As for ethical considerations, consent to participate in the study was systematically sought. In addition, confidentiality and anonymity were guaranteed.

III. RESULTS

Table 1 Sociodemographic Characteristics of the Sample

| Sociodemographic characteristics | f | % |
|------------------------------------|----|----|
| Age | | |
| Less than 25years | 25 | 33 |
| 25-34 years | 32 | 42 |
| 45-54 years | 14 | 18 |
| 55 years and more | 5 | 7 |
| Gender | | |
| Male | 8 | 10 |
| Female | 68 | 88 |
| Years of work experiences | | |
| Less than 5 years | 28 | 36 |
| 5-10 years | 40 | 52 |
| 11-20 years | 7 | 9 |
| 20 years and more | 1 | 1 |
| Education | | |
| Certificate from nursing school | 37 | 48 |
| Bachelor | 35 | 45 |
| Master | 4 | 5 |
| Type of healthcare facility | | |
| Referral General Hospital | 14 | 18 |
| Clinics | 14 | 18 |

| | | |
|--|-----------|--------------|
| Health centres | 48 | 62 |
| Marital status | | |
| Single | 18 | 23 |
| Married | 52 | 68 |
| Separated/Divorced/Widowed | 6 | 8 |
| Having received specific training on the involvement of male partners in SRH services | | |
| No | 2 | 2.6 |
| Yes | 74 | 97.4 |
| Total | 76 | 100.0 |

Slightly more than 40% of respondents (42%) are aged 25-34, and the majority are female (88%). More than half of respondents (52%) have between 5 and 10 years of experience. The majority of respondents have either an A2

diploma (48%) or a bachelor's degree (45%). The majority of respondents (62%) work in health centers, and most are married (68%). Specific training on male partner involvement is commonly received among them.

Table 2 Midwives' Knowledge Regarding Partner Involvement

| | Yes | | No | |
|--|------------|----------|-----------|----------|
| | f | % | f | % |
| Integration of current guidelines on the involvement of male partners in SRH | 72 | 94.74 | 4 | 5.26 |
| Definition of partner involvement in SRH services provided by midwives | | | | |
| The involvement of the partner in all stages of reproductive care, including family planning, pregnancy, and postnatal care. | 42 | 55.26 | 34 | 44.74 |
| The partner's presence during prenatal consultations only. | 20 | 26.32 | 56 | 73.68 |
| Emotional support from the partner, without their physical presence at consultations. | 13 | 17.11 | 63 | 82.89 |
| Having been informed about the benefits of partner involvement in SRH | 70 | 92.11 | 6 | 7.89 |
| Key benefits of partner involvement in SRH | | | | |
| Improved maternal and neonatal health | 65 | 85.53 | 11 | 14.47 |
| Stronger family ties | 63 | 82.89 | 13 | 17.11 |
| Greater family involvement | 65 | 85.53 | 11 | 14.47 |
| Better shared decision-making within the couple | 71 | 93.42 | 5 | 6.58 |
| Better communication within the couple | 61 | 80.26 | 15 | 19.74 |
| Support for effective family planning | 64 | 84.21 | 12 | 15.79 |
| Fewer pregnancy-related complications | 69 | 90.79 | 7 | 9.21 |
| Better prenatal and postnatal care | 63 | 82.89 | 13 | 17.11 |
| Stronger emotional and psychological support for the patient | 61 | 80.26 | 15 | 19.74 |
| Key role of partners in SRH services | | | | |
| Emotional support | 9 | 11.84 | 67 | 88.16 |
| Financial support | 51 | 67.11 | 25 | 32.89 |
| Joint decision-making | 37 | 48.68 | 39 | 51.32 |
| Risks associated with the lack of partner involvement in SRH services | | | | |
| Decreased adherence to maternal care | 13 | 17.11 | 63 | 82.89 |
| Increased obstetric complications | 45 | 59.21 | 31 | 40.79 |
| Negative impacts on couple management | 15 | 19.74 | 61 | 80.26 |
| Strategies used to involve partners in SRH services | | | | |
| Education sessions for partners | 12 | 15.79 | 64 | 84.21 |
| Joint consultation with male and female partners at the consultation | 52 | 68.42 | 24 | 31.58 |
| Written information given to partners | 8 | 10.53 | 68 | 89.47 |
| Recommended timing for partners to be present | | | | |
| During prenatal consultations | 17 | 22.37 | 59 | 77.63 |
| During maternity education sessions | 43 | 56.58 | 33 | 43.42 |
| During childbirth | 13 | 17.11 | 63 | 82.89 |
| After childbirth (postpartum) | 23 | 30.26 | 53 | 69.74 |
| Type of information most often shared with partners in the context of SRH | | | | |
| Maternal and child health | 9 | 11.84 | 67 | 88.16 |
| Family planning | 16 | 21.05 | 60 | 78.95 |
| Postnatal care | 36 | 47.37 | 40 | 52.63 |
| Prevention of sexually transmitted diseases | 15 | 19.74 | 61 | 80.26 |

A large majority (94.74%) of respondents say that current guidelines for male partner involvement in SRH services are integrated, while a small proportion (5.26%) believe the opposite.

The majority of respondents (55.26%) believe that partner involvement means their presence at all stages of reproductive care. However, 44.74% believe that involvement is limited to prenatal consultations. A significant proportion (73.68%) think that the partner's presence is limited to these consultations, while only 17.11% consider emotional support, without physical presence, to be sufficient.

A majority of respondents (92.11%) were informed about the benefits of partner involvement in SRH services, indicating a good level of awareness. Improved maternal and neonatal health (85.53%) and reduced pregnancy complications (90.79%) were the most frequently perceived benefits of this involvement. Other benefits included strengthened family ties (82.89%) and increased family commitment (85.53%).

Emotional support is considered the main role of partners by only 11.84% of respondents, while the majority (88.16%) believe that they should primarily provide financial support. Joint decision-making is perceived as important by approximately 48.68% of respondents. The risks most often identified in the absence of partner involvement include a

decrease in admission to maternal care (82.89%) and an increase in obstetric complications (59.21%).

The main strategies for encouraging partner participation are joint consultations (68.42%), followed by partner education sessions (15.79%). However, a majority of respondents (89.47%) believe that written information provided to partners is not an effective method. The majority of respondents suggest that partners should be present during maternity education sessions (56.58%), but there is also a significant proportion (77.63%) who believe that they should only be present after the prenatal consultation. The most frequently shared information concerns family planning (78.95%) and postnatal care (52.63%). Information on the prevention of sexually transmitted diseases is shared less often (80.26%).

There is strong recognition of the benefits of male partner involvement in SRH services, particularly for maternal and newborn health, as well as for reducing pregnancy-related complications. However, a significant proportion of respondents appear to have a limited view of partner involvement, mainly focusing on emotional or financial aspects. The most common strategies for involving partners include joint consultations and educational sessions. Finally, although partner involvement is viewed positively, additional information strategies may be needed to overcome barriers related to the physical presence of partners during consultations.

Table 3 Midwives' Attitudes Toward Partner Involvement

| | Agree | | Neutral | | Disagree | |
|--|-------|------|---------|------|----------|-----|
| | f | % | f | % | f | % |
| Involving partners in SRH care is essential to improving maternal health outcomes. | 7 | 9.2 | 65 | 85.5 | 4 | 5.3 |
| The presence of partners during SRH consultations can create a more supportive environment for the patient. | 38 | 50.0 | 38 | 50.0 | | |
| Men play a key role in promoting sexual and reproductive health within their relationships. | 41 | 53.9 | 35 | 46.1 | | |
| SRH consultations should systematically include partners, unless the patient objects. | 34 | 44.7 | 38 | 50.0 | 4 | 5.3 |
| I think that partner involvement is an important practice, but one that is difficult to implement due to social norms. | 41 | 53.9 | 35 | 46.1 | | |
| I believe that partner involvement improves the quality of reproductive health care. | 48 | 63.2 | 27 | 35.5 | 1 | 1.3 |
| Partners should play an active role in decisions related to reproductive health. | 41 | 53.9 | 34 | 44.7 | 1 | 1.3 |
| Midwives have a crucial role in promoting partner involvement. | 43 | 56.6 | 32 | 42.1 | 1 | 1.3 |
| The presence of partners could interfere with the SRH consultation process. | 36 | 47.4 | 37 | 48.7 | 3 | 3.9 |
| You are ready to encourage partner involvement in SRH services. | 41 | 53.9 | 35 | 46.1 | | |

The majority (85.5%) of respondents are neutral about the importance of involving partners in improving maternal health outcomes. Respondents are divided, with an equal number agreeing and remaining neutral. A slight majority (53.9%) recognize the key role of men in promoting sexual and reproductive health.

The majority are either neutral (50%) or in favor (44.7%) of systematically including partners in SRH consultations, unless the patient objects. More than half of respondents (53.9%) believe that social norms make it difficult to implement partner involvement.

A large majority (63.2%) of respondents believe that partner involvement improves the quality of SRH care. More than half of respondents (53.9%) believe that partners should play an active role in decisions related to reproductive health. The majority (56.6%) believe that midwives play a crucial role in promoting partner involvement.

Nearly half (47.4%) of respondents believe that the presence of partners could interfere with SRH consultations, while a large proportion remain neutral (48.7%). Just over half of respondents (53.9%) are willing to encourage partners to participate in SRH services.

Table 4 Midwives' Practices Regarding Partner Involvement

| | Never | | Rarely | | Often | |
|--|-------|------|--------|------|-------|------|
| | f | % | f | % | f | % |
| Invite partners to attend prenatal information sessions. | 2 | 2.6 | 31 | 40.8 | 43 | 56.6 |
| Discuss the importance of partners being present with patients during SRH consultations. | 1 | 1.3 | 34 | 44.7 | 41 | 53.9 |
| Encounter resistance from patients to involving their partners in consultations. | 2 | 2.6 | 40 | 52.6 | 34 | 44.7 |
| Receive regular continuing education on involving partners in SRH care. | 2 | 2.6 | 42 | 55.3 | 32 | 42.1 |
| Ensure that facilities are equipped to comfortably accommodate partners in SRH services. | | | 41 | 53.9 | 35 | 46.1 |
| Encourage partners to attend prenatal consultations. | 1 | 1.3 | 24 | 31.6 | 51 | 67.1 |
| Offer reproductive health education sessions for partners. | 1 | 1.3 | 43 | 56.6 | 32 | 42.1 |
| I work with other colleagues to promote partner involvement in SRH services. | 2 | 2.6 | 44 | 57.9 | 30 | 39.5 |
| Receive institutional support to promote partner involvement in reproductive health care. | 6 | 7.9 | 46 | 60.5 | 24 | 31.6 |
| Do you currently encourage partner involvement in SRH consultations? | | | 32 | 42.1 | 44 | 57.9 |
| Integrate partner involvement into your SRH consultations. | 6 | 7.9 | 40 | 52.6 | 30 | 39.5 |
| Encourage partners to participate in family planning sessions | | | 36 | 47.4 | 40 | 52.6 |
| Regularly discuss the importance of partner involvement with your patients during SRH consultations. | 1 | 1.3 | 48 | 63.2 | 27 | 35.5 |
| Include partners in decision-making on reproductive health issues, with the patient's consent. | | | 41 | 53.9 | 35 | 46.1 |
| Refuse to allow a partner to be present during an SRH consultation | 22 | 28.9 | 38 | 50.0 | 16 | 21.1 |

56.6% of participants often invite partners to attend prenatal information sessions. The majority of healthcare professionals actively involve partners in these sessions, although some do so rarely or never. 53.9% often discuss this with patients. 42.1% often receive continuing education on this topic.

Training courses are fairly widespread, but more than half of professionals rarely attend them. 46.1% often ensure that facilities are comfortable for partners. 67.1% often encourage partners to attend prenatal consultations. The majority of professionals actively encourage partners to get involved in prenatal consultations.

Although these sessions are offered, a significant proportion of professionals do not offer them frequently. 39.5% often collaborate with their colleagues to promote partner involvement. Interprofessional collaboration could be strengthened to further promote partner involvement in SRH care.

Although nearly one-third of professionals receive support, the majority rarely do, which can be a barrier to partner involvement. Most professionals regularly encourage partners to participate, although this practice is not systematic for everyone.

The integration of partners in SRH consultations remains partial, with more than half of professionals doing so infrequently or never. Encouraging participation in family planning is practiced by a slight majority of professionals, which shows some receptivity to this approach.

Discussion about the importance of involving partners is not yet systematic, although it is practiced by one-third of professionals. The inclusion of partners in decisions is

balanced between those who do so regularly and those who do so only rarely. The presence of partners is generally accepted, although one-fifth of professionals admit to frequently refusing their presence.

IV. DISCUSSION

➤ *Sociodemographic Characteristics of the Sample*

The sample in this study shows a significant concentration in the 25-34 age group (42%), a trend often observed in reproductive health studies (Niemants, 2019). This age group represents a key phase in individuals' reproductive lives, when the demand for SRH care is highest. The predominance of women in the sample (88%) is also common in SRH studies, which focus primarily on women and their maternal health (Magne et al., 2022).

In addition, the majority of respondents with 5 to 10 years of professional experience (52%) and a high level of education (93% with a diploma or bachelor's degree) indicate a skilled population capable of understanding and applying advanced SRH practices. This educated population, although committed to reproductive health practices, may encounter social and cultural barriers that prevent more active participation by male partners.

➤ *Respondents' Knowledge of Partner Involvement in Sexual and Reproductive Health Services*

The majority of respondents (94.74%) believe that guidelines regarding male partner involvement are integrated into SRH services, but actual practice still appears to be limited, particularly in prenatal consultations (73.68%). Financial support from partners is widely perceived as essential (88.16%), while joint decision-making (48.68%) and joint consultations (68.42%) are considered factors that promote greater involvement of partners. However, the

perception of the ineffectiveness of written materials (89.47%) highlights the need for more interactive and engaging communication strategies, such as face-to-face education sessions (Niemants, 2021). A need for additional information is also noted to encourage partners to attend consultations. Although the benefits of participation are recognized, restrictive perceptions persist regarding the role and commitment of partners.

Our data are similar in some respects to those of Johnson (2021), who found that 70% of midwives often had varied knowledge about the benefits of partner involvement, including the advantages of including partners in patient support. However, some aspects are similar to the findings of Garcia (2020), who reported that only 45% of midwives were aware of national guidelines regarding partner involvement in SRH services. Our findings contrast with studies on midwives' knowledge, which reveal significant gaps in their understanding of sexual and reproductive health (SRH) practices. Research has shown that although midwives receive basic training on contraceptive methods and reproductive health, many midwives lack up-to-date information on new techniques and best practices (Molla, 2018).

According to several studies (Masella & Godard, 2024 ; Niemants, 2021), the benefits of such participation are well documented, but obstacles remain, including restrictive perceptions of men's roles, lack of time for joint consultations, and cultural resistance in some regions. Financial support is also often cited as essential for involving partners in SRH (Saad, 2023).

The majority of respondents (94.74%) seem to be aware that existing guidelines include the participation of male partners, but this recognition does not always translate into everyday practice. According to previous studies (Beauchemin-Roy, 2018; René et al., 2025), although the guidelines are widely available, their implementation remains complex due to cultural and social norms that are deeply rooted in communities.

It is interesting to note that the involvement of male partners is mainly perceived as beneficial in prenatal consultations (73.68%), which is consistent with research conducted by (Carillon et al., 2017 ; Inghels et al., 2017 ; Ruzagira et al., 2017), which showed that the presence of partners during this period improves health outcomes for mothers and newborns. However, barriers persist in terms of accessibility, communication, and perceptions of reproductive health, which explains the low participation in certain contexts.

➤ *Midwives' Attitudes Toward Partners' Involvement in Sexual and Reproductive Health Services*

Midwives seem to share a nuanced position regarding partner involvement in SRH. Although a majority believe that male involvement can improve maternal health outcomes, approximately 53.9% of respondents mention that social norms make it difficult to implement such involvement. A significant proportion of midwives (63.2%) believe that

involving partners improves the quality of SRH care, but more than half of respondents remain neutral about systematically including partners in consultations. These data highlight the existence of persistent social and cultural barriers to implementing these practices. Midwives play a key role in this dynamic, as more than half of midwives consider their role to be central in promoting this participation (Gonin et al., 2022). Our findings are consistent with those of our predecessors. Indeed, midwives' attitudes toward partner involvement in SRH care also play a crucial role in the engagement of men and women. Many midwives support the idea of a couple-centered approach (Yaya, 2019).

A majority of midwives (53.9%) recognize the importance of men's role in promoting sexual and reproductive health, but the systematic inclusion of partners in SRH consultations appears to remain a complex issue. According to (Saad, 2023), although health professionals recognize the need for this involvement, internal resistance exists, particularly due to perceptions of gender roles in many cultures. This phenomenon has also been observed by (Godard et al., 2023 ; Masella & Godard, 2024, 2025), who show that social norms defining femininity and masculinity often limit men's participation in reproductive healthcare.

The neutral stance of many respondents regarding the inclusion of partners in SRH consultations (50% neutral, 44.7% in favor) is also indicative of the complexity of professionals' attitudes toward this issue. The importance of midwives' role in promoting participation is undeniable, but their ability to overcome social and cultural barriers is still insufficient (Bertine, 2024). Midwives must therefore strengthen their educational and supportive role with women and their partners.

➤ *Midwives' Practice Regarding Partner Involvement in Sexual and Reproductive Health Services*

The actual practices of midwives, such as inviting partners to prenatal information sessions (56.6%) and encouraging their presence during consultations (67.1%), are a good indicator of a willingness to promote active participation. However, a significant proportion of midwives rarely actively invite partners. This shows that, although midwives recognize the importance of partners being present, the practice of involving them remains uneven and is often dependent on the patient's situation. (Bertine, 2024).

The results show that 56.6% of midwives regularly invite partners to prenatal information sessions. However, the actual involvement of partners remains limited, with a significant proportion not frequently involving partners (46.1%). This observation is consistent with the work of (Ngo Mayack, 2019; Perron & Shaw, 2019), which indicates that despite recognition of the importance of participation, the practice remains largely underdeveloped.

Midwives are willing to encourage participation, but interprofessional collaboration to ensure this involvement is limited. Bertine's study (2024) suggests that improving midwifery training and implementing more appropriate strategies to encourage partners to participate actively could

strengthen this dynamic. A more systematic approach to managing consultations and a review of existing structures could also improve participation rates.

Numerous studies have highlighted the impact of gender norms on men's participation in SRH services. The study by Godard et al. (2024) highlights that in many societies, reproductive health is still perceived as being the sole responsibility of women, leading to low involvement of men. Furthermore, in cultures where fatherhood and women's health are separate domains, men may be reluctant to become actively involved (Niemants, 2021).

The data collected suggests that although partner involvement is recognized as beneficial, further efforts are needed to strengthen this involvement in SRH care. According to Saad (2023), the implementation of innovative educational strategies, such as targeted awareness campaigns and community interventions, could play a key role in changing cultural perceptions about male involvement. Healthcare professionals, particularly midwives, should be trained not only to promote reproductive health among women, but also to engage male partners in constructive and inclusive dialogue, as recommended by Perron and Shaw (2019).

V. CONCLUSION

The study results indicate that partner involvement in SRH is recognized for its benefits, but its implementation remains uneven, influenced by sociocultural factors and professional practices. These results show that partner involvement in SRH services is essential for improving health outcomes, but remains limited by social norms. Furthermore, midwifery practices, although encouraging in some contexts, remain uneven, with notable differences between urban and rural areas, reflecting the impact of socioeconomic and cultural constraints.

Targeted interventions, better training for professionals, and increased interprofessional support are needed to overcome these challenges and maximize the impact of partner involvement in sexual and reproductive health. To encourage this participation, it is essential to strengthen educational and support strategies within the healthcare system. Midwives, as the first point of contact in this area, play a crucial role in promoting this participation and must be supported through ongoing training and appropriate resources.

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