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Promoting husbands' participation in birth preparedness and complication readiness in The Gambia: Implications for gender transformation

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Abstract

This study assessed the gender-transformative implications of a training aimed at transforming gender norms and promoting husbands' involvement in birth preparedness and complication readiness in The Gambia. The study used an observational quantitative evaluation design, beginning with a pre-training assessment of 100 husbands and a post-training assessment of 96 husbands who participated in the training. It also incorporated a qualitative component comprising 12 interviews with the pregnant wives of husbands who participated in the training. The results indicated that husbands reported an increased understanding of pregnancy and childbirth due to the training. As a result, 73% reported accompanying their wives for skilled birth attendance and 60% reported saving money for potential delivery-related complications. Pregnant women have also reported improved communication with their husbands. However, sustaining these changes may require broader socioeconomic considerations. These insights, along with observations and reflections from training sessions, provide valuable lessons for organizations implementing similar programs. *(Afr J Reprod Health 2025; 29 [6s]: 65-75).*

Keywords: Childbirth, male involvement, husbands, pregnancy, gender transformative

Résumé

Cette étude a évalué les implications d'une formation visant à transformer les normes de genre et à promouvoir l'implication des maris dans la préparation à l'accouchement et aux complications en Gambie. L'étude a utilisé un modèle d'évaluation quantitative observationnelle, en commençant par une évaluation avant la formation de 100 maris et une évaluation après la formation de 96 maris qui ont participé à la formation. Elle a également intégré un volet qualitatif comprenant 12 entretiens avec les femmes enceintes des maris ayant participé à la formation. Les résultats indiquent que les maris ont déclaré mieux comprendre la grossesse et l'accouchement grâce à la formation. En conséquence, 73% d'entre eux ont déclaré accompagner leur femme pour un accouchement assisté par un personnel qualifié et 60% ont indiqué qu'ils économisaient de l'argent pour faire face à d'éventuelles complications liées à l'accouchement. Les femmes enceintes ont également fait état d'une meilleure communication avec leurs maris. Cependant, le maintien de ces changements peut nécessiter des considérations socio-économiques plus larges. Ces informations, ainsi que les observations et les réflexions issues des sessions de formation, constituent des enseignements précieux pour les organisations qui mettent en œuvre des programmes similaires. *(Afr J Reprod Health 2025; 29 [6s]: 65-75).*

Mots-clés: Accouchement, implication des hommes, maris, grossesse, transformation du genre

Introduction

Birth preparedness and complication readiness are approaches that encourage the prompt use of skilled birth attendance (SBA) during pregnancy, delivery, and the postnatal period[1,2]**.** The global impact of this approach is based on the theory that when a family and pregnant women prepare for childbirth and are aware of pregnancy and delivery complications, it reduces unnecessary household delays in accessing maternal and newborn health services. Birth preparedness and complication readiness have been identified as essential components of safe motherhood programs aimed at reducing maternal morbidity and mortality[1,2].

Involving husbands in women's and newborns' health during childbirth—especially in supporting women during and after pregnancy and ensuring skilled care for both birth and complications—is crucial for ensuring that women

are birth-prepared and complication-ready[3,4]. This involvement can directly address the gender-related factors that affect maternal and newborn health[3,4]. Furthermore, it strategically helps to dismantle gender barriers that hinder access to maternal healthcare services[4]. However, in The Gambia, husbands' involvement in birth preparedness and complication readiness is notably low[5] due to their limited knowledge of pregnancy issues.

This lack of understanding can result in delays in pregnant women seeking timely obstetric care[6], given that husbands can decide when and where their wives can seek care. Among Gambian women, factors leading to unskilled birth deliveries also include the heavy workloads pregnant women face and the lack of a division of labor within the household[7]. The expectations placed on women require pregnant women to manage significant household chores, leaving them with limited opportunities to seek care[7]. When it comes time to deliver, the decision to seek care often lies outside the woman's control and often with the husband[7]. These factors may explain why pregnant women are often unprepared for childbirth and potential delivery-related complications. Husbands can ease the heavy workloads of their pregnant wives and have control over household decisions, finances, and means of transportation, which are necessary for ensuring that pregnant women have access to timely care. Therefore, increasing husbands' awareness of the importance of their involvement in arranging for skilled birth attendance (SBA) and taking prompt action in case of complications during pregnancy, delivery, and the postpartum period is important. Additionally, raising awareness on the importance of husbands' engagement in discussions about pregnancy status of their wives and childbirth preparations, as well as providing support with childcare and household chores, is crucial for ensuring that women are birth prepared and complication ready.

To encourage husbands to take part in these activities, the "Shifting Gender Norms for Improved Maternal and Adolescent Health" (SIMAH) project was launched. The aim of the SIMAH project was to address both demand-side and supply side factors that influence maternal health and access to maternal health services for pregnant women. A key focus of the project was to promote husbands' participation in birth preparedness and readiness for complications. At the beginning of the project, the team conducted a baseline survey to examine the social and cultural factors that influenced husbands' participation in these areas. The findings from this baseline survey revealed that a general lack of knowledge about danger signs during pregnancy, along with traditional beliefs that view pregnancy and childbirth solely as women's responsibilities, significantly hindered husbands from engaging in birth preparedness and complication readiness[8]. The project team used these findings to design and implement a training aimed at transforming gender norms, while encouraging husbands to participate in birth preparedness and readiness for complications. The training aimed to challenge patriarchal views surrounding pregnancy and childbirth, which are influenced by social and gender norms, attitudes, and beliefs. It also sought to increase awareness and promote critical thinking about gender roles and relations and power imbalances that affect husbands' attitudes and behaviors, encouraging them to adopt more equitable and gender-transformative perspectives.

This study assessed the gender-transformative implications of the training on transforming gender norms and promoting husbands' involvement in birth preparedness and complication readiness. Along with observations and reflections from the implementation of the training, the study also provides important insights for organizations implementing similar male engagement programs.

Methods

Study design

This study used an observational quantitative evaluation design with a descriptive qualitative component involving individual in-depth interviews to assess the gender-transformative implications of a training in transforming gender norms and promoting husbands' participation in birth preparedness and complication readiness.

Participants

The study recruited and compared 100 husbands who participated in the pre-training assessment

with 96 husbands who were available for the post-training assessment three months later. The inclusion criteria required that the husbands have pregnant wives who gave birth within the past five months. Husbands who did not meet these criteria or who were sick or traveling during the enrollment period were excluded. A significant challenge we encountered was securing husbands' participation during the enrollment period due to their conflicting work schedules. To address this, we conducted recruitment during the evening and engaged husbands in scheduling appointments to accommodate their work and other commitments. This strategy notably increased participation rates during recruitment and training and could be beneficial for similar male engagement programs.

We recruited husbands whose wives were pregnant or had given birth within the past five months because we expected these husbands to be able to provide up-to-date information about maternal health issues because their wives were either currently pregnant or had given birth relatively recently. This made it more likely for them to recall pregnancy and related complications, and their level of involvement in these issues. The minimum age for participation in these husbands was 18 years, in accordance with the legal age of marriage in Gambia. Community volunteers working alongside the project's research and training coordinator facilitated the recruitment process.

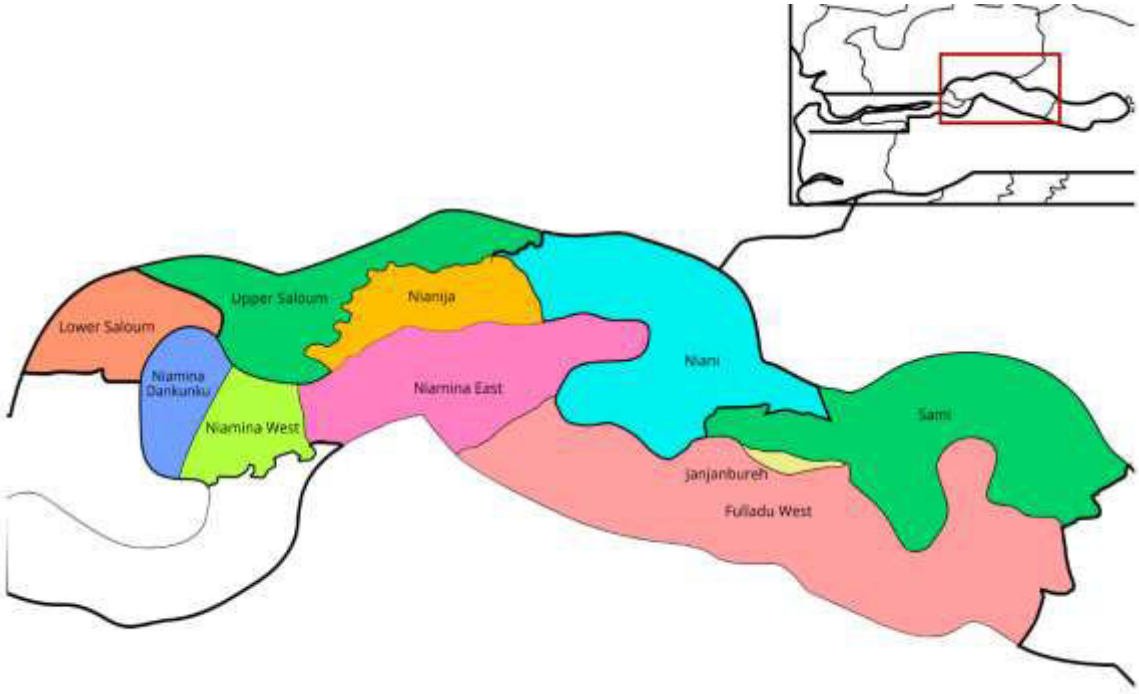
In addition, twelve (12) pregnant wives of the 96 husbands who had attended the training were recruited for individual in-depth interviews. These women were selected to triangulate and validate the data collected from their husbands, focusing on their experiences as young, polygamous, or first-time women. Their recent or ongoing reproductive experiences were expected to provide current insights into pregnancy, childbirth, and their relationships with their husbands. This was because they had either recently entered their reproductive years or given birth relatively recently. These women were recruited from six specific project intervention communities chosen to represent diverse ethnic groups and cultural contexts that have been identified as significant factors influencing husbands' participation in birth preparedness and complication readiness[6]. The qualitative interviews with pregnant women were limited to 12 to maintain a focus on the study's primary emphasis on husbands. Another reason for limiting the number of interviews with pregnant women to 12 was that the data collection process followed the principle of saturation[9].

Intervention

The intervention involved delivering one-month training for husbands. The training was held in three different communities in the Nianija District, located in the Central River Region of The Gambia (Figure 1). Previous research has shown that women in this district face a high rate of maternal mortality[10], primarily because of significant challenges in accessing maternal health services. These challenges stem from structural barriers, including inadequate road networks and sociocultural norms, which are deeply rooted in gender inequality.

The training sessions addressed main topics, such as gender and power, fatherhood, couple communication and decision-making, childcare, pregnancy and childbirth, and birth preparedness and complication readiness (See Table 1 for details on curriculum content by session).

Each session lasted approximately eight hours, including two breaks for breakfast and lunch. The sessions were led by two facilitators: a female state-registered nurse and a male social worker with experience in delivering gender and development training to adolescent girls and boys as well as women and men. Sessions included lectures, simulation exercises, and role-plays in real-life scenarios. The sessions aimed to address patriarchal notions about pregnancy and childbirth – rooted in social norms, attitudes, and beliefs – and increase awareness and critical thinking about gender and power imbalances by addressing their root causes and stimulating a process of transformation that starts at the individual level, influencing attitudes and behavior to become more gender-transformative and equitable. The sessions were held in school halls and at a community health post in one of the project intervention communities. These venues were chosen because they provide a secure and safe environment for sensitive discussion.



Source: Wikimedia Commons

Figure 1: Map of districts of central river region, including Nianija District

Table 1: Overview of the training sessions

Session	Objectives
Gender and power	To raise critical awareness around underlying gender and power relations between husband and wife that can affect birth preparedness and complication readiness among pregnant women and husbands' participation in these activities.
Fatherhood	To train and empower young fathers and provide them with professional and peer support to fully engage in the upbringing of their children.
Couple communication and decision-making	To promote healthy couples' communication and joint decision-making to improve reproductive health outcomes.
Childcare	To increase awareness about the role of husbands in childcare and to learn about a baby's care needs and reflect upon men's capacity to satisfy these needs and to reflect on how gender stereotypes influence a father and mother's behavior towards their children.
Pregnancy and childbirth	To share ideas and experiences about the role of the husbands during birth, and to prepare husbands to accompany their pregnant wives during delivery, including improving their knowledge of the danger signs of pregnancy.
Birth preparedness and complication readiness	To train husbands on what to prepare in anticipation of delivery and potential complications. Emphasis includes the need to save money, identify the health facility/place of delivery, mode of transport, ways of communication, identify a blood donor, travel to a nearby health facility, plan for an emergency, and prepare items for pregnant women to use during labor and after delivery, as well as essential items for the new born baby.

Additionally, holding the sessions in either the school hall or community health post helped avoid noise and distractions.

The design and implementation of the training were guided by the Socio-Ecological Model (SEM)[11] and Gender Transformative Approach (GTA)[12]. SEM emphasizes the importance of addressing multiple levels of influence to create a significant impact. Similarly, GTA suggests that achieving gender transformation requires changes in gender norms, roles, and inequalities at levels beyond the individual. We chose to use the SEM and GTA models because they consider various factors such as age, education, and ethnicity, which were found to interact in complex ways at the individual, household, and community levels[8]. These interactions affect husbands' participation in birth preparedness and readiness for complications during the baseline survey[8].

We also drew upon sociological theories of gender and masculinities that emphasize how gender inequalities are reproduced or transformed through everyday interactions within the home[13]. The use of these theories in the design and implementation of the training provides a structured environment for husbands to 1) question and critically reflect on gender norms and how these norms shape their lives; 2) practice equitable and non-violent attitudes and behaviors in a supportive and comfortable setting with their wives; and 3) internalize these new attitudes and behaviors by applying them in their own lives and relationships[13]. We hypothesized that by becoming aware of inequalities, reflecting on the consequences of rigid norms, and learning and practicing new skills—such as childcare, effective spousal communication, and joint decision-making—in a safe, non-judgmental peer environment, husbands can experience changes in their attitudes and behaviors towards pregnancy and childbirth. This, in turn, would improve their participation in birth preparedness and complication readiness, benefit both maternal and child health outcomes for pregnant women, and contribute to greater gender equality and improved power relations.

Study outcomes

Key indicators of husbands' participation in birth preparedness and complication readiness in this study included arranging for skilled birth attendance (SBA) during delivery; taking prompt action in case of complications during pregnancy, delivery, and the postpartum period; engaging in discussions about pregnancy status and childbirth preparations; participating in joint decision-making regarding sexual and reproductive health; and providing support with childcare and household chores.

Data collection

Data collection was conducted using a questionnaire administered by trained research assistants who were proficient in the local languages Wolof, Mandinka, and Fula. The questionnaire asked information about respondents' age, religion, ethnicity, and occupation, as well as their experiences about having a child and involvement in birth preparedness and complication readiness and views on gender roles and relations between husband and wife related to child care, pregnancy and childbirth. The first author supervised the data collection process to ensure that the research procedures were properly followed. Data were collected at two intervals: first, during the pre-training assessment, and then again after the training, with the post-training assessment taking place three months later. Measures were implemented to minimize the loss to follow-up. Husbands who did not attend the follow-up assessments were contacted via phone calls or home visits.

On the other hand, qualitative data was collected through in-depth individual interviews with pregnant wives of husbands who participated in the training. A question guide was developed and utilized to facilitate the collection of qualitative data, asking pregnant women about their perceptions of their husbands' participation in issues related to pregnancy and childbirth as well as their readiness for birth and potential delivery-related complications.

Data management and analysis

All the completed questionnaires were thoroughly reviewed to ensure completeness. Data from the completed questionnaires were entered into an Excel spreadsheet and screened for errors before exporting them to Stata MP17 for analysis. The data were cleaned by running the frequencies of all the variables to check for incorrect coding. After double-checking the raw data, corrections were made before analysis. Pre-training and post-training assessment data were analyzed and reported using simple percentages and chi-square tests, with a significance level set at $p < 0.05$.

For qualitative data management and analysis, interviews with pregnant women were audio-recorded, transcribed verbatim, translated into English, and analyzed thematically using NVivo software.

Results

Sociodemographic characteristics of participants

Table 2 shows the sociodemographic profiles of the husbands in the pre- and post-training assessments. On average, husbands are 31 years old and predominantly belong to the Fula ethnic group. They all identify as Muslims and primarily work as farmers.

Effects of the training on husband's knowledge and practices

Table 3 presents the effects of the training on husbands' knowledge and practices related to birth preparedness and complication readiness. The findings show that the percentage of husbands who reported accompanying their wives for antenatal care visits increased by 73% after the training, and the differences observed before and after the training were statistically significant, suggesting a greater sensitivity to the importance of maternal and child healthcare and services among husbands associated with training. Additionally, 60% reported saving money for potential delivery-related complications, and those who took action by identifying the mode of transport for delivery also increased from 16% before training to 63% after training. However, there has not been much reported increase among husbands who recognize the need to identify the mode of transport and health facilities as part of the things a husband can do to prepare for his wife's delivery.

The training has significantly increased husbands accompanying their pregnant wives to health facilities for skilled birth attendance. This was narrated by a 27-year-old pregnant woman with two children: *"When I was going to the hospital, I used to go alone. However, since he returned from training, he has been accompanying me to the hospital for my antenatal care visits".*

A 20-year-old pregnant woman also had this to say: *"Previously, my husband only saved money for the naming ceremony during my pregnancy. However, after undergoing training, he recognized the importance of setting funds aside for my antenatal care visits and potential delivery-related complications. Now, it's not just about the naming ceremony anymore."* This shared experience, which resonates with many women, illustrates the effects of training on husbands' practices related to birth preparedness and complication readiness.

Effects of the training on spousal communication

Table 4 shows the effects of training on couples' communication regarding reproductive issues. The results showed that, where less than one-fifth of the husbands claimed to have discussed pregnancy and health status with their wives before the training, approximately three-quarters of the husbands frequently talked about pregnancy and health status with their wives following the training. A similar increase was observed in the couple's discussion of concerns about raising a child

Traditionally, issues surrounding raising a child were left to the decision of the female gender, as explained by this woman: *"Many husbands think that pregnancy and childbirth are the domain of women. So, because of this traditional perception, many of them hardly discuss with their wives on matters related to pregnancy or even raising the child".*

Based on the above statement, it can be argued that training of husbands has contributed to

Table 2: Socio-demographic characteristics of husbands

Variable	Pre-training assessment (before training) n =100 (%)	Post-training assessment (3 months after training completed) n = 96 (%)
Age (mean, SD) years	31.7 (4.61)	30.8 (4.36)
Ethnicity		
Fula	79 (82.3)	79 (82.3)
Wolof	14 (7.95)	10 (10.4)
Mandinka	7 (7.52)	7 (7.52)
Religion		
Muslim	100 (100%)	96 (96%)
Occupation		
Farmer	79 (82.3)	79 (82.3)
Civil Servant	3 (1.70)	0
Other	18 (21.9)	17 (17.7)

Table 3: Knowledge and practices among husbands that participated in the training

Variable	Pre-training assessment n =100 (%)	Post-training assessment n = 96 (%)	P-value
What are some things a husband can do to prepare for his wife's delivery			
Identify mode of transport	28 (15.91)	16 (16.7)	
Identify health facility	0	4 (4.17)	
Ever accompanied wife for antenatal care visits			
Yes	15 (8.52)	79 (82.3)	<0.0001
Actions taken in preparation for wife's delivery			
Save money	23 (13.07)	58 (60.4)	
Identify mode of transport	29 (16.48)	61 (63.5)	

Table 4: Communication about pregnancy status and having or raising children

Variable	Pre-training assessment n =100 (%) Often	Post-training assessment n = 96 (%) Often	P-value
Frequency the husband discussed with his wife of pregnancy status and health	33 (18.75)	74 (77.1)	0.963
Frequency the husband discussed with his wife about concerns of having or raising the child	33 (18.75)	73 (76.0)	<0.001

Note: Only percentages of respondents who reported "often" are included in the table above, both before and after the training.

breaking down this gendered pattern, promoting empathy with the wife and involvement by the husband in the care of the baby from before birth. In many instances, pregnant wives mentioned that the training provided to their husbands helped improve their communication with them about their health and pregnancy status. One of the pregnant women added: *"During my last pregnancy, my husband never talked to me about my health and pregnancy. But now, after the training in my current pregnancy, he is always interested to know how I am feeling with the baby. I attribute this to the training he attended".* Another pregnant woman added: *"The training has been very helpful for us. Since they returned from the training, we have been hearing kind and supportive words from them."* These and other related statements suggest that the training has contributed to more involvement and

Table 5: Gender relations between men and women

Variable	Pre-training assessment n =100 (%) Agree	Post-training assessment n = 96 (%) Agree	P-value
Feeding and bathing the kids are the mother's responsibility	58 (32.95)	8 (8.33)	<0.001
If a man always changes and baths his kids, it is shameful for his wife	49 (27.8)	11 (11.5)	<0.001
Pregnancy and childbirth are exclusively women's domain	26 (14.7)	1 (1.04)	<0.001
It is culturally forbidden for a man to be present during delivery	79 (82.3)	31 (32.3)	<0.001

improved communication between husbands and wives regarding issues of health and pregnancy.

Effects of the training on gender relations

Following the training, fewer husbands agreed with the statements that feeding and bathing the kids is the mother's responsibility, childbirth is exclusively women's domain, and that it is culturally forbidden for a man to be present during delivery (Table 5). These findings suggest that training conducted for husbands contributed to a change in traditional gender roles. Typically, roles such as childcare are perceived as the domain of women, but this perception has changed, and husbands now participate in these roles. A 25-year-old pregnant woman narrated this change*: "After the training, we noticed positive changes in our husbands' behavior. They started bathing and dressing the kids, which they had not done before."*

The training not only contributed to changing gender roles but also improved gender relations between husbands and their wives. A 24-year-old pregnant woman was quoted saying: *"Previously, asking for money during antenatal care visits and 'talking back' when my husband spoke led to violence. However, there is now increased communication and understanding between us. I can now rely on him for financial support during antenatal care visits, and we can talk freely without any problems."*

Observations and reflections from the training sessions

Our observations and reflections from the training indicate that although the training has resulted in an increase in husbands accompanying their wives for skilled birth attendance, saving money for potential delivery-related complications, and improving communication with their spouses, training alone may not sustain the reported behavioral changes among husbands because the attitudes of husbands can still be influenced by broader socioeconomic factors beyond the training sessions. Several key moments during the implementation of the training highlighted these challenges, reflecting the complexity of engaging husbands in birth preparedness and readiness for complications. One of the challenges is competing social responsibilities that limit the availability of husbands. Additionally, our interactions with husbands during the training revealed that although husbands may want to be involved in issues related to birth preparedness and complications, their participation can be limited by some women who may view husbands' involvement in pregnancy and childbirth as an intrusion, as explained by a 23-year-old pregnant woman during the qualitative interviews. The pregnant woman explained: "*In my ethnic group, it is not customary for a man to be present during his wife's delivery, as it is believed to bring bad luck. I personally believe that men should not be involved in matters of pregnancy and childbirth because these are women's issues".*

Discussion

The results presented in this study highlight the gender-transformative implications of training in transforming gender norms and promoting husbands' participation in birth preparedness and complication readiness. The positive contribution of training to transforming entrenched attitudes

towards gender roles and age-appropriate behavior has been documented in various contexts. For instance, a study revealed that the training of health workers on gender transformative approaches in Kenya improved the quality and inclusiveness of sexual and reproductive health services for young people, including those with diverse sexual orientations and gender identities[14]. Similarly, another study revealed that gender transformative approach training conducted for teachers in Zambia successfully shifted their gender biases over the course of the intervention[15]. In Rwanda, training designed to promote male engagement in reproductive and maternal health and violence prevention among couples also demonstrated positive outcomes, such as increased male accompaniment at antenatal care visits[13].

The interactive and participatory nature of the training fostered active engagement, collaboration, and exchange of personal experiences among participants[8]. This transformative process equipped husbands with the knowledge and confidence to challenge existing gender norms that hindered their engagement in birth preparedness and complication readiness[8]. For instance, ten of the 12 pregnant women interviewed reported that their husbands had conducted training and organized community engagement forums to emphasize the importance of husbands' participation in preparing for childbirth and addressing potential complications. These findings suggest that participation in training has a positive influence on the behavior of the participating husbands.

However, our observations showed that training alone may not sustain long-term behavioral changes in husbands. Husbands' attitudes and behaviors can still be influenced and reinforced by broader socioeconomic factors that extend beyond individual training sessions. These include the competing social responsibilities of husbands, which were found to have limited their participation in the training, as well as the prevalence of unfavorable gender norms among some women who perceived husbands' involvement in pregnancy and childbirth as an intrusion.

These findings align with findings from other studies suggesting that gender transformative interventions focusing solely on individual-level masculinity norms may not adequately address men's behaviors because men's behavior is also shaped by broader complex socioeconomic forces[16-18]**.** These structural forces significantly impact men's agency in adopting gender-equitable attitudes and behaviours[16-18], suggesting the need to accompany training with specific interventions targeted at changing wider socioeconomic factors that can limit husbands' participation in birth preparedness and complication readiness. Such interventions should consider a relational approach that integrates husbands into efforts to empower women without perpetuating the notion of helping or saving women. Such interventions should also try to navigate the tension between promoting constructive male involvement and respecting women's autonomy given that some women may welcome husbands' participation in birth preparedness and complication readiness, while others see it as an intrusion.

Study strengths and limitations

This study makes substantial contribution to the literature on male participation and gender transformative approaches for improving maternal health in an African country. The results and reflections from the training sessions indicate that educating husbands about pregnancy issues can significantly transform their gender attitudes and norms towards pregnancy and childbirth and improve their understanding and involvement in activities related to childbirth preparation and potential delivery-related complications. This engagement is crucial for ensuring that pregnant women have access to quality emergency obstetric care services, which are essential for preventing maternal deaths in countries like The Gambia.

A major limitation of this study is its small sample size which did not allow for multivariable analysis of the quantitative data to eliminate the effects of confounders. Another limitation is the study's limited timeframe, which prevents the assessment of the long-term effects of the training on actual behaviors. Instead, this study measures support for these behaviors, which may be a precursor to actual changes. Another limitation is the reliance on self-reported data rather than direct observation of household dynamics, potentially

affecting the accuracy of husbands' reported levels of participation.

Future research should investigate the potential unintended consequences of the training on marital relationships and women's perceptions of changes in husbands' gender norms and attitudes towards pregnancy and childbirth. Understanding whether women feel empowered or perceive a loss of control over reproductive decisions can provide deeper insights into the broader impact of the training.

Conclusion

This study highlights the gender-transformative implications of training in transforming gender norms and promoting husbands' participation in birth preparedness and complication readiness. We conclude with two important insights and lessons that can inform future implementation of male engagement programs.

First, we conclude that there is a need to adopt a 'cultural respectability approach' in promoting husbands' participation in birth preparedness and complication readiness. We generated this approach from the field and defined it as the recognition of the inherent cultures and traditions of women and their husbands. Using this approach, we acknowledged and respected women's autonomy while also emphasizing the importance of husbands' participation in birth preparedness and complication readiness. This approach facilitated productive discussions and enabled husbands during the training sessions and women during the interviews to share their thoughts and experiences openly. Second, in engaging husbands in gender-transformative training programs, it is important to schedule training sessions to accommodate husbands' conflicting work and other commitments. This strategy facilitated the effective participation of husbands in the training despite their competing social responsibilities. These insights highlight practical strategies to enhance husbands' participation in training. By addressing logistical challenges, cultural sensitivities, and communication approaches, future initiatives can optimize outcomes and promote sustainable changes in male engagement in maternal and child health.

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Ethical approval

The study was approved by the Scientific Coordinating Committee (SCC) at the Medical Research Council The Gambia (MRCG) at the London School of Hygiene and Tropical Medicine (LSHTM) and The Gambia Government/Medical Research Council The Gambia (MRCG) Joint Ethics Committee (approval number 28209). The participants provided verbal and written informed consent. Before commencing the research components of the training, the research team adhered to an Ethics Charter signed by all members. Each participant was enrolled in the study based on voluntary and informed consent. This involved providing detailed information about the study, including its purpose, duration, procedures, right to decline or withdraw at any time without consequences, potential benefits of participation, incentives offered, and contact information for any questions or concerns. This information was presented in participants' preferred language and format.

Competing interests

The authors have declared that no competing interests exist.

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Contribution of authors

ML designed the study. ML, AD, and MJ contributed to data collection. ML conducted qualitative and quantitative data analyses and interpretation of the data, with input from OE. ML wrote the first and final draft of the manuscript. All authors critically reviewed the manuscript for important intellectual content and approved the final version.

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