CLINICAL STUDY

Men's Involvement in Safe Motherhood

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Abstract

Objective: Safe motherhood incentives have not been successful in reducing maternal mortality in Nigeria probably because interventions are centered around the women who are rather passive in decision making on reproductive health in an average African family setting.
The aim of this study is to look critically into men involvement in pregnancy care to assess their role in decision making in pregnancy care, the level of men's awareness of danger signs of obstetric emergency and to investigate the attitude, action and perception of men in obstetric emergencies.
Materials and Methods: This study was conducted in Ife Central Local Government of Osun State, Nigeria. Obalufon and Sabo communities were purposely selected to incorporate the three major ethnic backgrounds in Nigeria. Multi-stage sampling technique and serial recruitment were used. Gender-specific focus group discussions were also done. Data analysis was done using computer statistical package for social sciences.
Results: Three-hundred married (131 men and 169 women) respondents in reproductive age group were selected and interviewed. Men were the major decision makers in pregnancy with women playing supportive role. Less than 15% of female respondents took part in decision making. Men's role was found to be mainly in the area of financial support. The level of men attendance at the antenatal clinic was very low (7.9%). Men's awareness of danger signs in pregnancy was high and in obstetric emergency many men believed the women should make the decision. Health seeking behaviour when in need of emergency obstetric care was independent of age, educational status and ethnicity.
Discussion: The study showed male gender supremacy in decision making. It also showed that a high level of male knowledge on reproductive health and obstetric care was needful to improve pregnancy outcome. To a varying extent, men supported their wives during pregnancy in terms of financial contribution and accompanying them to health facility for delivery but major decisions were made by men. Spousal attendance especially at antenatal clinic and delivery should be encouraged as this served as avenue to educate them.

Keywords: safe mother hood, male involvement, pregnancy care

Özet

Güvenli Anneliğe Erkeklerin Katılımı

Amaç: Nijerya'da anne ölümünü azaltmak için başlatılan güvenli annelik girişimleri başarılı olmamıştır. Bunun olası nedeni normal bir Afrikalı aile ortamında kadınların üretim sağlığında kararsız ve etki altında olmalarıdır. Bu çalışmanın amacı eleştirel bir yaklaşımla erkeklerin gebelikte bakıma katılımı ve bu konuda karar alma rolü, gebelikte acil durum göstergelerine duyarlılıkları, sezgi ve davranışlarını değerlendirmektir.
Materyal ve Metot: Bu çalışma, Nijerya'da Ife Merkezi Yerel Hükümeti Osun Eyaleti sınırları içinde, Nijerya'daki üç ana etnik yapıyı oluşturmak üzere özellikle Obalufon ve Sabo toplumlarının tercihli katılımları ile yapıldı. Çok-evreli örnek alımı ve seri kayıt yöntemleri kullanılmıştır. Cinsiyete özgü odaklanmış grup tartışmalarına yer verilmiştir. Veri analizleri, sosyal bilimler için hazırlanmış bilgisayar istatistik programları ile yapılmıştır.
Sonuçlar: Çağrıya olumlu yanıt veren doğurganlık çağında evli 300 kişi (131 erkek ve 169 kadın) seçilerek görüşme yapıldı. Gebelikte, erkekler karar alıcı kadınlar ise destekleyici durumda idiler. Kadınların karar almaya katılımı %15'ten

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azdı. Erkeklerin ana rolü parasal destek idi. Erkeklerin doğum kliniklerine katılımı düşüktü (%7.9), erkekler çoğunlukla gebelikte tehlike göstergelerinin bilincinde olup, bu konuda karar yetkisini kadınlara bırakmışlardı. Gebelikte acil durumlarda sağlık yardımı arayışı yaş, eğitim düzeyi veya etnik yapı ile ilişkili değildi.
Tartışma: Bu çalışma, erkeklerin karar alma üstünlüğünü göstermiştir. Aynı zamanda, gebelik sonuçlarında düzelme için erkeklerin üremede sağlık ve gebelikte bakım konularında daha fazla bilgilenmeleri gerektiğini göstermiştir. Değişik sosyal yapıdan erkekler, gebelikte eşlerini parasal açıdan destekleyip doğum için sağlık merkezlerine birlikte gelseler de, bu konularda temel kararlar erkeklerce verilmekteydi. Erkekler, eğitilmeleri için doğum öncesi kliniklere ve doğum olayına katılıma özendirilmelidir.
Anahtar sözcükler: güvenle annelik, erkek katılımı, gebelikte bakım

Introduction

Despite decades of safe motherhood programs, maternal mortality rate in Nigeria is between 800 and 1500 deaths per 100 000 live births (1,2). The major causes of death include: postpartum hemorrhage, obstructed labour, hypertension, postpartum infection and abortion related complications (2).

To reduce maternal mortality and morbidity, interventions had been made in the areas of implementation of safe motherhood initiatives and hospital care. Despite the interventions, studies continue to show that existing strategies to save mothers' lives had been less successful than the child survival program (3). This may be due to less emphasis placed on the adverse maternal outcomes due to social factors that surround decision making at home in obstetric care (4-6). Many pregnant women are dying in Nigeria not because of pregnancy as a biological function, but because of the neglect they suffer in the management of the event particularly from home. These include having to take permission from their husbands before seeking care, even in emergencies when their husbands may not be available, having to do strenuous work during pregnancy. Some family or cultural dictates even when this is dangerous to their health in pregnancy women in Sub-Saharan Africa are in a disadvantaged position in terms of decision making at home and they are not in control of their sexuality. From research evidences, women have little control at all (6). They may have to have as many children as possible even when their health would not be supportive.

It has been suggested that fertility, particularly in developing countries would have been lower if women were in the position to decide when to become pregnant and how many children they want to have, because it is women that undergo all the sicknesses associated with pregnancy and delivery and they may lose their lives as a result of pregnancy and childbirth (7). The husband's permission is required before a woman can take any step regarding her own health (6). Though studies have been done on male involvement in reproductive health (8-12), only few studies have examined the role of men in obstetric care despite the knowledge that in the African traditional setting, men determine where and when their spouses visit health care facility (8,13-17).

The aim of this study is to examine critically men's involvement in pregnancy care in Obalufon/Sabo communities in Ife-Central Local Government Area, Southwest, Nigeria with respect to their understanding of dangerous pregnancy signs and symptoms, level and aspects of care given by men during pregnancy and to determine how decisions are taken during pregnancy.

Materials and Methods

This study was conducted in Ife Central Local Government of Osun State, Southwest Nigeria. Obalufon and Sabo areas were purposely selected to incorporate the three major ethnic backgrounds in Nigeria. The design is a cross-sectional descriptive study. A total of 300 respondents (169 married women within the reproductive age of 15 to 49-years who have had at least one live birth and 131 married men] were interviewed.

Multistage sampling technique was used to select the enumeration areas and the streets where the interview was conducted. Serial selection of the study population was done until the sample size was exhausted. Quantitative data were collected using structured questionnaires. The questionnaires were pre-tested at urban-day area and necessary corrections were made before administering them. Two structured questionnaires were employed; one for the male respondents and the other for the female respondents. The questionnaires had four sections, viz.

Section A - for socio-demographic characteristics,
Section B - this was aimed at identifying decision makers in pregnancy care,
Section C - to examine the level of men's role in pregnancy care,
Section D - to investigate the attitude and action of men in obstetric emergency. Also this section was aimed to assess level of men's awareness of danger signs in pregnancy.

Both qualitative and quantitative methods of data collection were used. Interviewer-administered questionnaire was used. The service of an interpreter was employed among the Hausa speaking respondents. To further complement the study, focus group discussion was conducted among four homogenous groups of six participants-two male groups and two female groups. Note materials and tape recorder were also used for data collection during focus group discussion.

Data analysis was done using statistical package for social sciences (SPSS) software. Results were displayed in charts and tables. Test of association was determined using the χ^2

Table 1. Socio-demographic characteristics of respondents

Characteristics	Male respondent		Female respondent	
Age	**Frequency (%)**		**Frequency (%)**	
≤20	-		6	(3.6)
21-30	22	(16.8)	63	(37.2)
31-40	32	(24.4)	73	(43.2)
41-50	50	(38.2)	7	(16.0)
51-60	18	(13.7)	-	
61-70	9	(6.9)	-	
Educational level				
None	27	(20.6)	27	(16.0)
Primary	49	(37.4)	44	(26.0)
Secondary	34	(26.0)	53	(31.4)
Tertiary	21	(16.0)	45	(26.6)
Occupation				
Farming	18	(13.7)	17	(10.0)
Trading	66	(50.4)	95	(56.0)
Civil servant	41	(31.3)	44	(26.0)
Professionals	2	(1.5)	1	(0.6)
Others	4	(3.1)	13	(7.4)
Religion				
Christianity	68	(51.9)	102	(60.4)
Islam	60	(45.8)	67	(39.6)
Traditional religion	3	(2.3)	-	
Ethnicity	**Male respondent**		**Female respondent**	
Yoruba	62	(47.3)	108	(63.9)
Igbo	20	(15.3)	5	(2.9)
Hausa	49	(37.4)	53	(31.4)
Others			3	(1.8)

test. Level of significance was placed at $p<0.05$. Written and recorded qualitative data were transcribed into the computer. Permission to conduct the study was obtained after proper counseling. Only those who agreed to take part in the study were interviewed. A written consent form was provided and signed by all respondents who participated in the study.

Results

A total of 300 respondents were interviewed [131 males (43.7%) and 169 females (56.3%)]. Out of the 300 respondents; 170 were Yorubas, 25 Ibos, 102 Hausas and 3 other tribes. Thirty eight percent of the male respondents were between ages 41-50 while 43.2% of the female respondents were between ages 31-40 (Table 1). Men were the major decision-makers with the women playing supportive role. Fifty-eight percent of the male respondents and a significant proportion of female respondents (70.4%) said both husband and wife were involved in deciding when to get pregnant. Twenty five percent of females and 26% of male respondents believed that the husbands should decide when their wives get pregnant. However majority of both respondents believed that the husband should decide the number of children while both should decide the place of delivery (Table 2).

Financial contribution was the most prominent role of men in pregnancy care (89% of males said they paid the hospital bills while 91.7% of females said their husbands paid hospital bills when they were pregnant. Other roles men played during pregnancy included reminding wives of the medications, accompanying them to labour during delivery, helping in households chores and helping in taking care of other children (Table3). Men's level of awareness of danger signs in pregnancy was high with 96.9% of the respondents recognizing that hypertension is a dangerous sign in pregnancy, 89.3% believed that prolonged labour is dangerous.

Other reported danger signs included vaginal bleeding (88.5%), drainage of amniotic fluid (83.2%), abdominal pain (67.9%), swollen feet (48.1%), fatigue (46.6%) (Figure 1). Table 4 showed the attitudes and actions in obstetrics emergencies. When the husband refuses to give consent for doctor's intervention, 52 (35.7%) of the males and 51 (30.2%) of the females believed that the women should decide on their own, 46 (35.1%) of men and 58 (34.3%) of the women believed

Table 2. Distribution of decision-makers in pregnancy

		Male		Female	
		Frequency (%)		**Frequency (%)**	
Decision: To get pregnant	Husband	34	(25.95)	43	(25.44)
	Wife	17	(12.98)	5	(2.96)
	Both	77	(58.78)	119	(70.42)
	Parent	3	(2.29)	2	(1.18)
Decision: Number of children	Husband	65	(49.62)	51	(30.18)
	Wife	2	(1.53)	16	(9.47)
	Both	49	(37.4)	8	(48.52)
	Parent/In-law	15	(11.45)	20	(20.83)
Decision: Place of delivery	Husband	29	(22.14)	52	(30.77)
	Wife	26	(19.85)	18	(10.65)
	Both	75	(57.25)	97	(57.40)
	Parent	7	(0.76)	2	(1.18)

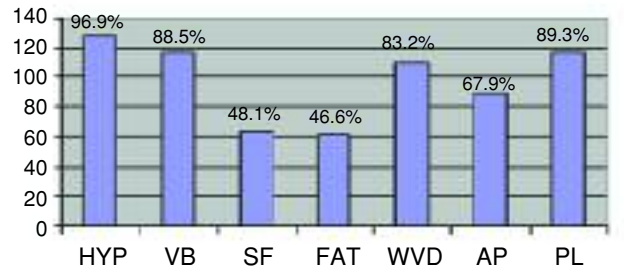
Table 3. Role of men in pregnancy care

	Male		Female	
	Frequency	%	Frequency	%
Accompany wife to clinic	10	7.66	19	11.2
Accompany wife to delivery	75	57.3	126	74.6
Remind wife of medication	85	64.9	128	75.7
Remind wife of clinic visit	42	32.1	41	24.6
Payment of hospital bills	114	87.0	155	91.7
Care of other children during pregnancy	33	25.2	54	32.0
Encourage to do difficult job	11	8.4	20	11.8
Help in household chores	41	31.3	20	26.6

that the pregnant woman should inform the husband's parents. When the husband is not around, 55 (42.0%) of the men and 83 (49.1%) of the women believed that the woman should decide on her own while 53 (40.5%) of the males and 50 (29.6%) of the females believed that she should go to husband's parents for assistance while less than one-third said they would wait for their husbands. Tables 5-8 showed the relationship between selected variables and decision making in pregnancy care. It was shown that irrespective of the level of education or ethnicity, the decision when to get pregnant and the number of children to have, were the prerogative of the man or at best of both but with the women playing a minimal role ($p<0.05$). Tables 9 and 10 showed that the husband approval of caesarean section was not influenced by ethnicity or education.

The qualitative data was gathered during focus group discussion. These extracts were reported verbatim and they include:

Extract 1: Women younger than 35 years;



HYP: HYPERTENSION
VB: VAGINAL BLEEDING
SF: SWOLLEN FEET
FAT: FATIGUE
WVD: WATERY VAGINAL DISCHARGE
AP: ABDOMINAL PAIN
PL: PROLONGED LABOUR (>12HRS)

Figure 1. Men awareness of danger signs of obstetrics emergencies

A 32-year old woman said "My husband is caring and he helps me in household work when I'm pregnant. He pays hospital bill but does not follow me to antenatal clinic because he has to go to work".

Another 34-year old woman said "My husband and I decide when to get pregnant but we are having problem with decision concerning number of children. He wants four and I want three".

Extract 2: Women older than 35 years;

A 40-year old woman said "Many husbands just leave home in the morning, return at night, such a husband does not know about caring for his wife during pregnancy. My husband is an example. I do things by myself. When it is an emergency, he takes me to the hospital and he pays".

A 45-year old woman said "Some husbands know about symptoms and signs of emergency, unless they are pretending. My husband watches me carefully whenever I am pregnant".

Extract 3: Men younger than 35 years;

A 28-year old man, among the six people in this group said "It is the duty of both to decide on issues concerning pregnancy. But you know, we don't have time for attending the clinic with wives. I have to provide for the family".

Table 4. Attitude and action in obstetrics emergencies

		Male		Female	
		Frequency	%	Frequency	%
Wife's action in emergency-pregnancy/delivery care when the husband is not giving his consent for doctor's intervention	Wait for husband	19	14.5	28	16.6
	Decide on her own	52	39.7	51	30.2
	Inform husband's parents	46	35.1	58	34.3
	Inform his relatives	1	0.70	1	0.6
	Others	4	3.1	7	4.1
What wife would do when she is in need of emergency care in the absence of her husband	Go to husband's parents	53	40.5	50	29.6
	Wait for the husband	2	1.5	4	2.4
	Decide on her own	55	42.0	83	49.1
	Go to her parents	1	0.75	16	9.5
	Look for relatives	16	12.2	14	8.3

Table 5. Effect of level of education on who decides when to get pregnant

Level of education	Husband	%	Wife	%	Both	%	Parent/In-law	%
No formal education	13	(5.5)	6	(1.8)	32	(62.7)	-	
Primary	21	(22.6)	10	(10.8)	58	(62.4)	4	(4.3)
Secondary	30	(34.9)	6	(7.0)	49	(57.0)	1	(1.2)
Tertiary	11	(16.9)			54	(83.1)		

χ^2=23.309; *p*-value=0.025

Table 6. Effect of level of education on who decides the number of children

Level of education	Husband	%	Wife	%	Both	%	Parent/In-law	%	Other	%
No formal education	23	(45.1)	-		14	(27.5)	14	(27.5)		
Primary	39	(41.9)	11	(11.8)	32	(43.4)	11	(11.8)		
Secondary	35	(41.2)	6	(7.1)	36	(42.4)	8	(9.5)		
Tertiary	16	(24.6)	1	(1.5)	46	(70.8)	2	(3.1)		

χ^2=54.028; *p*-value=0.0001

Table 7. Effect of ethnicity on who decides when to get pregnant

Ethnicity	Husband	%	Wife	%	Both	%	Parent	%
Yoruba	48	(28.6)	15	(8.9)	102	(60.7)	3	(1.8)
Igbo	12	(50)	2	(8.3)	9	(37.5)	1	(4.2)
Hausa	12	(11.9)	5	(5.0)	84	(83.2)	-	-

χ^2=35.086; *p*-value=0.02

Table 8. Effect of ethnicity on who decides the number of children

Ethnicity	Husband	%	Wife	%	Both	%	Parent	%
Yoruba	67	(40.1)	12	(7.2)	84	(50.3)	2	(12)
Igbo	14	(58.3)	1	(4.2)	9	(37.5)	-	-
Hausa	27	(26.7)	5	(5.0)	38	(37.6)	-	-

χ^2=67.916; *p*-value=0.001

Another 31-year old man said "It is the duty of men to pay for hospital bill, help in some necessary things but not all. Decision should be made by men".

Extract 4: Men older than 35 year;

Table 9. Effect of level of education on husband approval of caesarean

Education	Yes	(%)	No	(%)
No formal ed.	36	(70.6)	15	(29.4)
Primary	75	(82.4)	16	(17.6)
Secondary	65	(77.4)	19	(22.6)
Tertiary	43	(70.5)	18	(29.5)

χ^2=3.996; *p*-value=0.262

Table 10. Effect of ethnicity on husband approval of caesarean operation

Education	Yes	(%)	No	(%)
Yoruba	113	(70.6)	47	(29.4)
Igbo	19	(79.2)	5	(20.8)
Hausa	85	(85.0)	15	(15.0)

χ^2=10.987; *p*-value=0.052

A 50-year old man said, "A man should be a helper to his woman at home during pregnancy. If there is emergency, he must make sure that he takes her to the hospital. I don't play with my wife's life. I love her".

A 48-year old man said, "We should know about emergency signs, although some wives fail to tell their husbands about how they feel when they are pregnant. It may be as a result of lack of trust".

Discussion

This study was based on the assumption that men showed less concern about pregnancy care, despite their prominent role in decision making in the patriarchal society in our study area. The study focused on how male ideology affects women even in their obstetric conditions. We also examined the practical implications of male gender supremacy in emergency obstetrics. This study showed that small percentage of females solely decide when to get pregnant. Likewise in deciding on the number of children, almost half of male (49.6%) respondents and about one-third (32.2%) of female respondents said the decision is given by the husbands. Men are therefore the major decision makers with the women playing the supportive role as reflected by the percentages of

both. This corroborates with the results of an earlier study which revealed that women have little control of their sexuality (4-7). This could be explained by the fact that there are some traditional norms that tend to sanction men's behaviour and make women more sexually submissive and less assertive. These include the stigma of divorce, the culture of total submission to husband, who is the head of the family. Consequently, women cannot determine when to have sex and the only period they are allowed to refuse sex is during menstruation, late pregnancy and post-partum breast-feeding (14,18,19). The fear of the social consequences of being beaten, divorced or abandoned, neglected etc. tend to take priority over the fear of the health consequences of such ill-timed sexual acts.

In this study, the result of decision-making in emergency obstetric care shows that the decision is not taken totally by the woman. For example, when asked what the woman would do when the husband is not around, less than half of male and female respondents (42% and 49.1% respectively) reply that the women should decide on their own. In addition, a high percentage of male respondents (40.5%) and one-third of female respondents said that the women should go to parents-in-law. This showed that even though women are major players in deciding during emergency situations, they still needed the approval of their husbands either directly or indirectly (through husband's parents). While this is in keeping with the findings of Stock in 1983 (20), it differed with that of the study done by Raimi, Adebiyi and Odebiyi in 2000, in which almost all the male and female respondents said that the women decide on their own (21).

It is assumed that men play little role in emergency conditions of their spouses. This study showed rather that men played important role in pregnancy care. The findings from focus group discussions clearly showed the level of men's understanding and participation during pregnancy period in this part of the developing country. They accompanied their partners to the hospital in the time of delivery (57.3% of male respondents and 74.6% of female respondents testified to this). Men make financial contribution for the health bills (87% of male respondents and 91.7% of female respondents asserting to this). Other supports rendered by men in time of the obstetric emergencies included helping in household chores. This is another point that gender researchers have not acknowledged. This again is an impressive departure from African traditional pattern of practice, where men do not do any household chores (18,22). The study showed that men in this area do that as a result of the obstetric condition of their partners. Payment of antenatal bill is a cultural responsibility of the husbands. A man who is not able to pay for his wife's hospital bills is looked at with disdain in the community and is not regarded as a responsible man in African concept of maleness (see comments on focus group discussion above). However, there was still low level of spousal attendance at the antenatal clinic. Only 7.7% of male had attended antenatal clinic with their spouses. This finding is collaborated in the focus group discussions. This is not in conformity with what obtains in some parts of the developed countries. Some studies had documented men participation in antenatal clinics and delivery (23-26).

There was high level of awareness of the signs and symptoms of pregnancy and labour by the men. Also, there was high knowledge of danger signs of obstetric emergencies. A high percentage of men would give consent for operative delivery, while few (24.4%) would not. This might be as a result of little knowledge of importance of these procedures. This is in conformity with the result of a survey done in Northern Nigeria (22).

The relationship between selected variables and decision making in pregnancy was determined. It was observed that the level of education affected the level of involvement of women in decision on pregnancy matters. High percentage of respondents with tertiary education (83.1%) said the decision on when to get pregnant was made by both the man and the woman as compared to just more than half observed in those without formal education. The same trend was observed in the decision about the number of children. However, the level of education does not seem to affect health-seeking behaviour in emergency as 70.6% of respondents with no formal education would approve caesarean section if the need arises, and 70.5% of those with tertiary education would do likewise. This is similar to the findings of Raimi, Adebiyi and Odebiyi in 2000, that there was no significant difference in health seeking behaviour during emergency situation as low and highly educated agreed in the same direction. There is no socio-economic differential in survival instinct as everybody would like to live (16).

Association of ethnicity and decision were also determined. It was observed that 40.1% of Yoruba respondents, 58.3% of Ibos and 26.7% of the Hausa respondents said that the decision on the number of children was made by the man. This made the patriarchal family system more prominent among the Yorubas and the Ibos. Age had no effect on decision making in pregnancy.

Conclusion

Male gender supremacy in decision making in pregnancy was shown in this study. There is relatively high level of awareness of danger signs in pregnancy by men. Men played important role in pregnancy care especially in financial support. High level of education brought more women into the place of decision making. The health seeking behaviour in emergency situation is not related to the levels of education, religion, age and ethnicity.

Efforts at reducing maternal mortality should be directed towards male and female education on pregnancy symptoms, signs and expectations during emergency situations. Male education on pregnancy care and other reproductive health issues should be a significant part of strategies for reducing maternal mortality. Spousal attendance, especially at antenatal clinic and delivery should be encouraged as this serves as an avenue to educate them.

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