The Culture of Male Supremacy and Emergency Obstetric Care: The Nigerian Experience[1]

DR. O. I. AINA[2]; PROF. A.A. ADEWUYI[3];
PROF. YINKA ADESINA[4] & DR.. A. ADEYEMI[5]

ABSTRACT

The maternal mortality ratio in Nigeria remains one of the highest in the world (WHO, 1990). Many intervention programs in this area have failed to achieve the desired purpose because efforts have been mainly in the area of hospital care or service delivery, without due cognisance being given to the androcentric behaviour which affects maternal roles, especially the dynamics of decision-making when emergency obstetric care service becomes necessary,

Using findings from a recently concluded study, the paper looks at the impact of the culture of male gender supremacy on women's reproductive rights and their total well- being. It explores the gender myths about pregnancy, and pregnancy outcomes, and the central role played by men in emergency obstetric conditions.

The study. which is an action-oriented study, was carried out in South-western Nigeria, by a multi-disciplinary research group, using a variety of data collection techniques – questionnaire survey, in-depth interview, Focus Group Discussions, direct observation, and exposure to educative materials -- posters,

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[2] Dr. O, I. Aina is an Associate Professor in the Department of sociology and Anthropology. Obafemi Awolowo University, Ile – Ife (OAU Ife), Nigeria

[3] Prof. AA Adewuyi is a Professor of Demography and Social Statistics at OAU Ife, Nigeria

[4] Professor Yinka Adesina is a Professor of Geography at OAU Ife, Nigeria.

[5] Dr. A. Adeyemi is a Lecturer, and a Consultant in the Dept of Obstetrics and Gynaecology OAU Ife.

talks/discussions, films, drama etc, Study findings showed that androcentric behaviour is a major determinant of pregnancy outcome, since men have almost absolute control over the choice of health care facilities used during pregnancy, the condition under which delivery takes place, diet during pregnancy, and the types of action taken in emergency obstetric conditions. Yet, the study found that most men lacked knowledge of what constitutes emergency obstetric conditions, appropriate actions to be taken, and a shallow knowledge of pregnancy, fertility and family planning. The study instituted an intervention program which was aimed at improving the knowledge of men in what constitutes emergency obstetric care. and also counselling on androcentric behaviours which may be detrimental to pregnancy outcomes, and the social dynamics of what constitutes a healthy family.

INTRODUCTION

It is now well known that poor emergency obstetric care is still responsible for a large proportion of maternal mortality particularly in the developing world. There is clearly a need to focus attention on this controllable cause of death of childbearing women. The best agents of change are usually the people directly affected: in this case the *husband* and *wife*. Women have been playing and still play major roles in ensuring good health for themselves in pregnancy. At least when the pregnancy is causing the woman some discomfort, she complains even if only to those who can give her very little assistance. Men also have potentially positive roles that can ensure proper emergency obstetric care for their wives. These roles are largely conferred on men because of their traditional leadership position in homes. However, men rarely play these roles effectively.

In recent times, researchers have begun to focus attention on the male factor in reproductive health matters (Bankole 1995: Bankole and Singh, 1998; Ezeh 1993). Hitherto, attention was on women alone, particularly when it came to family planning. This is understandable in view of the fact that more than 90%of the family

planning methods available are female specific. However, within the African environment where men play a dominant role in determining sexual and reproductive behaviour in their homes, men have a potentially positive role to play in the health-seeking behaviour of their wives, especially during pregnancy. In reality, it has been found that men have very little knowledge about pregnancy and pregnancy outcomes. This is aptly expressed in a common Yoruba expression and belief – "oyun nini ki nse aarun" ("pregnancy is not a disease"). If pregnancy is taken as a normal and routine phenomenon, it must necessarily provide the same experience for all women. A woman who experiences a traumatized pregnancy regime (e.g., episodes of illnesses and threatened abortion among others), is often seen as abnormal, lazy, and less valuable, compared to women with healthy pregnancy regimes. Hence, husbands, in most cases, feel less sympathetic with wives with recorded illness episodes during pregnancy.-

Despite the ignorance of men about the varying biological facts concerning pregnancy and its outcomes, they are culturally empowered to take important decisions relating to their wives' sexuality, health, pregnancy care, and childbirth. In most cases, husbands decide on when their wives should have sex, the number of children to have, and other reproductive experiences. Hence, in many cases, women have little or no control over their sexuality and sexual rights (Orubuloye et. al, 1992).

With such high mortality and morbidity ratios in Nigeria, like in many other African countries, the gender problematic, especially the one which affects women's reproductive health, continues to attract research attention. The tension between husbands and wives with regard to emergency obstetric care, particularly the tension created by specific male gender supremacy concepts, such as those which emphasize male authority and male choice in relation with the wife even in matters of life and death, needs a critical understanding and analysis. The culture of male superiority and authority over women's reproductive rights have implications for women's total well-being (see Adamchak and Adebayo, 1987;

Wa Karanja, 1983; Renne, 1993). In Northern Nigeria, Harrison noted the reluctance of men to grant permission for delivery through surgery when their wives were in prolonged labour. This is because they perceived this as a sign of reproductive failure. In many cases, failure to grant permission to wives in such cases often had disastrous consequences, i.e. the death of the women, or an experience of what is today known as VVF (Vesico Vaginal Fistulae) which is often caused by prolonged and obstructed labour.

Culture of Male Supremacy

No where is the culture of male supremacy better felt than in homes. The patriarchal traditional system confers on men a superior position in the family decision-making process. The cultural setting recognizes men as the dominant factor. The man is the head of the family, and the breadwinner. Even when life exigencies do not allow him to fulfil the role of a primary breadwinner, the culture still confers on him the final say on family issues. When it comes to reproductive health, the general attitude among men is that pregnancy is not a 'disease' and should not necessarily demand the same attention required for a sick person. It is, to many men, ridiculous for a woman to complain of agonizing discomfort during pregnancy. This means that the ignorance surrounding pregnancy and 'childbirth is real in Nigeria. The magnitude or level of this ignorance, especially as it relates to obstetric emergencies, is hardly given attention in the literature.

With the culture of total submission to the husband (who is the traditional head of the family) women are supposed to be generally sexually submissive and less assertive. Consequently, women cannot determine when to have sex. The only periods they are allowed to refuse sex is during menstruation, late pregnancy, and post-partum breast- feeding (Odebiyi, 1993; Orubuloye et al. 1992). According to de Zalduondo et al (1989), fear of the social consequences (being beaten, divorced, abandoned, neglected, among others) tend to take priority over fear of the health

consequences of such ill-timed sexual acts. Women, in many cases, require the express permission of their husbands to attend health centers, especially if the journey involves some distance to the health unit, and if she has to go unaccompanied (Stock, 1983).

Practical interpretations of male gender supremacy for obstetrics care are not well known. For example, what transpires in the reproductive decision-making process is not clear, particularly as it relates to men's knowledge of women's health. It is assumed that men's treatment of women's health, especially in the area of emergency obstetric care, may largely depend on the dominant cultural view of pregnancy and pregnancy outcomes rather than a medical understanding of the risk factors associated with pregnancy and it outcomes. Therefore, it is important to understand the role of men in women's reproductive health processes, especially emergency obstetric care, especially in a culture which is inextricably tied to polygyny, where children are perceived as 'assets', or 'family wealth' (Oni, 1996). Polygyny continues to flourish in most African societies despite exposure to western education and modernity (Ware, 1983; Karanja, 1987). Even in recent studies, Yoruba men continue to desire to marry many wives to satisfy their need for sex (Orubuloye, 1994), and for children (Karanja, 1987, 1994). Karanja argued that in many African societies, children are a source of pride, and often women define marriage primarily in terms of having children. Radcliffe-Brown (1950) remarked that the birth of the first child is customarily considered an essential step in the development of a marriage, because children unite the families of the husband and wife. The value of children therefore developed as a means of ensuring the survival of the family, clan or tribe.

Within the cultural context of male supremacy, this study explored the following issues: the extent of the involvement of men in the reproductive health of their wives, the level of the awareness that men have of the signs and symptoms of obstetric emergencies, the cultural factors hindering or enhancing male participation in reproductive issues, particularly in the area of emergency obstetric care, and an evaluation of the impact of a multi-media education

intervention on male attitudes on emergency obstetric care in a target study area in Southwest Nigeria.

On the whole, the African culture precludes men from the concerns associated with gestation and parturition as well as from the ordeals that surround pregnancy. Thus, African men exhibit genuine ignorance about matters relating to maternal risks in pregnancy. Unfortunately, with the weak position of women in decision-making, even with regard to issues concerning their reproductive health, the inaction of men to ensure prompt obstetric care could lead to maternal deaths particularly in cases that require emergency care. Awareness about the negative attitudes shown by men with regard to obstetric care calls for an urgent educational intervention that could modify behaviour in selected treatment areas. It is also important to revisit cultural options, which leave total control of female reproductive behaviour in the hands of men. Today, studies have found that women's decision-making authority and/or gender equity is a key factor shaping reproductive behaviour (Jejeebhoy, 1995; Dixon- Mueller, 1993; Kritz *et al.*, 2000).

RESEARCH METHODOLOGY

Study Location

This study was carried out in three rural towns in Osun State, Southwest Nigeria, The towns are Odeomu, Ejigbo, and Otan Aiyegbaju. The three towns were carefully selected to allow for comparison between treatment areas (Ode-Omu and Ejigbo), and the 'control town' (Otan-Aiyegbaju). The three towns have no direct link with one another and are sufficiently wide apart. However, they share similarities in terms of social characteristics. They can be described as rural centers, and they are less exposed to intervention the programmes of other projects that have already been conducted in some parts of the State. The strategy for intervention in the two treatment area was the same.

Data Collection Techniques

A variety of techniques was used to collect data during the various phases of the project. For the baseline survey, data were collected using interviews, surveys, in-depth interviews of key informants, and focus group discussions FGDs). The baseline survey was to determine the role of men in emergency obstetric care for their wives, and to document men and women's knowledge, attitudes, and practices (KAP) in situations relating to obstetric care and related emergencies, including heamorrhage, abortion, hypertension, infraction, obstructed labour among others. The overall objective of this phase was to identify factors required to design and successfully implement the intervention programme. The FGDs involved various social categories. The following criteria for group formation was used: gender, age, and opinion leaders. 12 FGDs were conducted per town, totaling 18 FGD sessions for the pre-intervention study, and another 18 FGDs for the post-intervention study.

For the baseline study, the sample from Odeomu and Otan Aiyegbaju was based on a random selection of households, while the sample for Ejigbo was a purposive targeting of exposed couples in the selected households. A total of 300 households were selected per town, while the husband and the wife in each household were interviewed separately. In selecting the wife(ves), preference was given to women within the reproductive age group in all the households. At Ejigbo, preference was given to exposed couples for interview, Exposed couples are currently pregnant women and their partners.

For the intervention phase in both Odeomu and Ejigbo a population-base intervention strategy was used. The intervention stage was developed using a multi-disciplinary panel comprising of health care personnel, social welfare personnel, sociologists, and psychologists. Essentially, the intervention focused on educating men in particular, but also women of child-bearing age, on ways of recognizing obstetric emergencies, its fatality and how maternal mortality and morbidity could be reduced based on cultural factors,

and an understanding of the gender role. The following specific intervention strategies were employed –

i. mobilisation workshop for men and women at Ejigbo and Odeomu;

ii. distribution of information material documenting the concept of emergency obstetric care, problems of maternal mortality and morbidity and advice on how to prevent such problems; and

iii. organizing seminars and lecture sessions to develop and improve the skills of health professionals in dealing with the problem of male gender role supremacy as it relates to women's reproductive health.

In the treatment areas, sensitisation workshops included visits to churches, mosques, guild meetings, as well as a series of educational intervention in town halls that lasted eight months.

A post-intervention survey was also carried out to assess the impact of the intervention programmes, and the extent to which they had helped to change men and women's attitudes about gender stereotypes, especially those relating to emergency obstetric care and outcomes. For the post intervention survey, the sample size of 300 households was again randomly selected in Odeomu and Otan Ayegbaju while 300 couples were randomly selected from exposed couples (that is, where the wife is currently pregnant) and households in Ejigbo.

RESULTS AND DISCUSSIONS

Characteristics of the Respondents

A total of 1,720 married men, and 1,957 married women were interviewed in the baseline and follow-up surveys. The age of the men ranged from 18 to 68 years for the baseline study, and 20 to 74 years in the follow-up (with a mean of 37.1 years). Also, the

women's age ranged from 15 years to 49 years for both the baseline and the follow-up studies (with a mean of 29.2 years).

The level of education of the respondents was generally low, for they were mostly rural dwellers. They were farmers (for the most part) and traders. However, men had a higher level of education compared to women. For the baseline survey, only 32% of the women sampled had ever attended school, while for men it was over 85%. This distribution was the same with the follow-up survey, in which less than 35% females, and over 86% males had attended school.

Male and Female Perception, Action, and Attitudes towards Emergency Obstetric Care

The average live birth for the sample population was 3.5, still-birth being 1.5, and miscarriages being 1.7. The relatively high figures on still-births and miscarriages are a cause for concern. A weak link was observed in the supply and use of medicare in the study area, a situation which showed that there is a serious problem in the area of emergency obstetric care (EOC). The study also found out that about 16% of the female population sampled reported that their last pregnancies occurred unexpecttedly. This unplanned or unwanted pregnancy usually resulted in inadequate care for the new-born and the mother. Also, over 20% of the women sampled reported that they had skipped or delayed antenatal care, either because of the poor financial situation of their family, or because of lack of support from their husbands. In many cases, the lack of proper antenatal care resulted in complications. As many as 10% of the currently pregnant women visit only Traditional Birth Attendants (TBAs), and/or spiritual homes for antenatal care, even though many of these practitioners lack adequate training to diagnose emergency obstetric conditions. Very often, pregnant women who visit them die for lack of proper obstetric care. During the fieldwork, 2 cases of obstetric emergency-related deaths were witnessed. One, was of a women at Odeomu, who had a still-birth of twins, and died subsequently because the decision to go to the

hospital had been delayed. The second, was the case of a young woman who died at Ejigbo Maternity Center because the husband failed to send her to the State Hospital Complex at Oshogbo. The reason he gave was that he had no money to send his wife to a State Hospital.

Generally, both husbands and wives were asked a number of questions relating to their understanding of the concept of emergency obstetric care: husbands' action, wives' action in the absence of the husbands, and the type of treatment preferred. Some of the emergency obstetric conditions examined in the study included – hypertension in pregnancy; prolonged labour, vaginal bleeding in pregnancy, foul odour after delivery, heavy bleeding 24 hours after delivery, inappropriate and bizarre thoughts.

It is important to note that more men (55%) than women (9%) showed total ignorance of emergency obstetric conditions such as hypertension in pregnancy. This is intricately linked with husbands' attitudes towards the traditional role of women, even in pregnancy. Irrespective of pregnancy conditions, husbands still believe that their wives should not be excused from 'carrying heavy loads' and 'pounding yams'. Pounded yam is the most popular dish among Yoruba families, and traditionally the most common family meal (taken almost on a daily basis). Field discussions with medical personnel showed that yam pounding has been known to be the cause high blood pressure conditions, especially in pregnancy.

Table 1 shows that in the baseline study, only 54.5% of husbands discouraged their pregnant wives from carrying heavy loads, while this figure rose to 76.3% in the follow-up study. Also, over half of the men sampled (50.3%) did not see anything wrong whith pregnant wives pounding yam, although the follow-up study showed that 60%of husbands would discourage pregnant wives from pounding yam. Figures on 'not currently pregnant' women (see Table 1) support the fact that women carry heavy loads and pound yams regularly. Until the intervention programme, husbands could not appreciate the detrimental effect of these activities on pregnant women's health. Traditionally, pounding of yam by wives is an obligation required of wives, and is seen as a good exercise

for pregnant wives. Even with the intervention programme instituted in this study, many husbands believe that *"it is the traditional role of women to prepare pounded yams for their husbands, pregnancy or no pregnancy"*. According to one of the husbands, *"one of the reasons for marrying a wife is ensuring that there is someone to pound your yam, pregnant or not pregnant*

On the whole, men tend to have limited knowledge with regard to pregnancy and pregnancy related conditions. Despite this limited knowledge, they more often than not, take important health decisions for their wives. The importance of the central role men play in health choices for theit wives is obvious in the decision-making dynamics in homes.

Table 1: Husband's Response to Wive carrying out Some physical Activity during Pregnancy

Type of activity	Currently pregnant		Not Currently Pregnant	
	Baseline N=181	Follow-up N=97	Baseline N=83	Follow-up N=222
1. Carrying Heavy Load				
i. Encourage;	25.5	9.3	40.8	26.3
ii. Discourage;	54.5	76.3	43.5	56.6
iii. Indifferent;	20.0	14.4	15.7	17.1
Total	100.0	100.0	100.0	100.0
2. Pounding Yam				
i. Encourage;	20.5	15.6	48.9	32.5
ii. Discourage;	49.7	60.0	25.8	49.0
iii. Indifferent:	29.8	14.4	25.3	18.5
Total	100.0	100.0	100.0	100.0

Decision-making in the family

A number of questions were asked to determine decision-making patterns in the family, especially as concerns pregnancy and pregnancy outcomes. Some of these questions were –

1. Who decides when to have a baby?
2. Who decides where the baby is to be born?
3. What do you do if you need emergency obstetric care when your husband is absent?
4. Would your husband accept that you undergo a caesarian operation to have a child ?

Table 2 shows that husbands have over-riding power in deciding when to have a baby. Close to three-quarters of the respondents in the study area said that the husband made most of the decisions. Decision as to when to have a baby are rarely made by wives. Both the baseline and the follow-up surveys supported this assertion. A higher proportion of the female respondents who claimed that the decision as to when to have a baby is jointly made is found in the baseline survey than in the follow up survey. One would have thought that the reverse would be the case considering the very educative intervention programs that followed the baseline survey. The explanation for this is that decisions as to how many children, when and where to have them, are the traditional and cultural responsibility of the husbands. So changing such cultural and traditional behaviour and attitudes would call for vigorous and persistent action. An intervention program of only eight months is not enough to bring about the desired change. Gender norms are often subtle and long lasting.

Answers to the question – 'who decides where a baby is to be born?' (see Table 3), also confirmed the supremacy of men over women in matters relating to obstetric care. It is a common practice for women to seek permission from their husbands before receiving any form of antenatal care (see Table 4). Even in the follow-up survey, more than two-thirds of the male respondents still

said that the husband should decide where to have a baby. Even when the husbands are away, many pregnant wives experiencing obstetric conditions prefer to go to their husbands' relatives rather than to their own for assistance (see Table 5). This trend was found in both the baseline and follow-up surveys. For instance, while about 21%, 5%, and 8.7% said they would go to their husbands' parents in Ejigbo, Odeomu, and Otan Ayegbaju respectively, only about 4%, 2%, and 1% in Ejigbo, Odeomu, and Otan Ayegbaju respectively said that they would go to their own relatives (Baseline Survey). The same trend was observed in the follow-up survey. The proportion that claimed that they would wait for their husbands are higher in the baseline survey than in the follow-up survey except for Otan Ayegbaju (the control town). Thus the intervention programme seemed to have some impacts on the experimental towns. This means that some of the traditional gender roles that are detrimental to women's health can be changed if properly targeted with enlightenment programmes.

Another emergency obstetric condition explored is the husband's attitudes towards caesarian section. The responses to the question – "would you approve that your wife undergoe a caesarian operation to have a child, if need be?" – showed that an average of 70% would allow their wives to undergo a caesarian section if it became a matter of life or death. Eventhough only a small proportion (about 3%) said they would never approve caesarian sections for their wives, this refusal should still be a cause for concern, since such attitudes could eventually lead to death, and thereby increase the maternal death rate in the country. Even in the follow-up survey, an average of 15% (in the experimental towns) still did not approve of caesarian sections for wives in emergency obstetric conditions.

Responses to other general questions continue to confirm the primacy of male supremacy in homes. Wives generally reported that husbands have overriding decision-making power on issues relating to their health. In the baseline survey, more than three-fifths of the wives claimed that their husbands made the choices of where they obtained treatment when they had health problems

during pregnancy. The picture was not significantly different in the follow-up survey. About 63% of the wives in Ejigbo 52% of wives in Ode-Omu, and about 71% in Otan Ayegbaju said that their husbands made the choice of where they obtained treatment for health problems during pregnancy. However, the proportion making a joint decision on where to obtain treatment was fairly higher in the follow-up survey than the one in the baseline survey.

Generally, wives reported that they would need to obtain permission from their husbands or their representatives before seeking emergency obstetric care (in the baseline survey, the distribution is 82% of wives in Ejigbo 85% in Ode-Omu, and 71% in Otan Ayegbaju). The few women who said they could take antenatal care without the express permission of husbands were found to be mainly women who lived separately from their husbands (especially in Ejigbo where most husbands were found to be migrant workers living in Abidjan, Côte d'Ivoire, or wives who no longer maintain cordial relationships with their husbands). This trend however changed in the follow-up survey, with fewer women reporting that they would need their husbands' express permission before seeking obstetric care (in the follow-up survey, the distribution of wives who still reported the need to wait for their husbands' permission before seeking care during obstetric emergencies was quite low in the experimental towns -- 22% of wives in Ejigbo, and 19% in Ode Omu, and relatively higher in the control town -- 42% of wives in Otan Ayegbaju).

That the male is dominant in the decision-making that affects emergency obstetric care, is confirmed in this study. In fact, information gathered using qualitative data-gathering techniques (for example focus group discussions, and in-depth interviews of key informants) espoused more of these social dynamics, especially information supporting the fact that the knowledge that men have concerning pregnancy and pregnancy outcomes is rather scanty, and in many cases this knowledge is more mythical, than pragmatic.

Table 2: Who decides when to have a baby?

Who decides when to have a baby?	Ejigbo N=264	Odeomu N=322	Otan N=380
BASELINE SURVEY			
1. Husband	43.6	50.0	70.6
2. Wife	6.1	6.3	7.9
3. Both husband and wife	40.9	35.1	19.2
4. Parents	1.6	1.9	0.8
5. Friends/relations	0.4	1.9	0.8
6. Others	7.5	0.9	0.5
TOTAL	100.0	100.0	100.0
FOLLOW-UP SURVEY	N=276	N=299	N=375
7. Husband	73.7	74.3	73.6
8. Wife	2 2	4.0	5.1
9. Both husband and wife	23.4	21.4	18.1
10. Parents	0.4	0.3	1.3
11. Friends and relations	-	-	0.8
12. Others	1.2	-	1.1
TOTAL	100.0	100.0	100.0

Table 3: Who decides where the baby should be born?

Who decides where the baby should be born?	Ejigbo N=230	Odeomu N=231	Otan N=377
BASELINE SURVEY			
13. Husband	95.2	94.4	59.2
14. Wife	-	-	19.6
15. Both husband and wife	1.3	5.2	18.3
16. Parents	-	0.4	1.3
17. Friends/relatives	3.5	-	1.3
18. Others	-	-	0.8S
TOTAL.	100.0	100.0	100.0
FOLLOW-UP SURVEY	N=240	N=292	N=285
19. Husband	67.9	67.1	73.6
20. Wife	4.5	3.1	1.7
21. Both husband and wife jointly	24.8	24.7	22.9
22. Parents	-	0.7	0.4
23. Friends/relatives	1.6	1.7	0 4
24. Others	1.2	2.7	-
TOTAL.	100.0	100.0	100.0

Table 4: Do you need to inform your husband before you seek any form of antenatal care?

Response Categories	Ejigbo N=295	Odeomu N=309	Otan N=378
BASELINE SURVEY:			
1.Always	80.7	79.0	84.4
2.Sometimes	8.9	10.0	6.9
3.If he is around	9.3	10.4	7.9
4.Not at all	1.2	0.7	0.8
TOTAL	100.0	100.0	100.0
FOLLW-UP SURVEY:	N=269	N=316	N=380
1.Always	85.1	82.9	86.6
2.Sometimes	8.6	7.3	5.5
3.If he is around	5.2	7.0	6.6
4.Not at all	1.1	2.8	1.3
TOTAL	100.0	100.0	100.0

Table 5: What do you do if you need emergency obstetric care when your husband is absent ?

Response Categories	Ejigbo N=258	Odeomu N=319	Otan N=378
BASELINE SURVEY			
1. Go to my husband's parents	21.3	5.0	8.7
2. Wait for my husband	0.4	0.9	4.2
3. Decide on my own where to go	71.3	91.9	85.5
4. Go to my relations	3.9	1.9	1.0
5. Don't know	3.1	0.3	0.5
TOTAL	100.0	100.0	100.0
FOLLOW-UP SURVEY	N=266	N=336	N=373
1. Go to my husband's parents	14.7	5.4	5.6
2. Wait for my husband	3.9	1.8	3.2
3. Decide on my own where to go	73.0	88.7	89.3
4. Go to my relations	1.5	1.0	1.8
5. Don't know	6.9	1.3	0.2
TOTAL	100.0	100.0	100.0

Societal Attitudes and Perceptions of the Role of Men in Emergency Obstetric Care (EOC)

Information on societal attitudes and the perception of the role of men in emergency obstetric care was collected using the focus group discussion (FGD) technique. Some 36 FGDs were conducted in the study areas (18 FGDs during the baseline survey, and 18 FGDs during the post-intervention survey, with a spread of 6 FGDs per town during each survey period). FGD groups were constituted based on gender and age. Female FGDs were grouped into women under 35 years of age, and women over 35 years of age, while male FGDs were grouped into men under 45 years of age, and men over 45 years of age. This age grouping for both men and women was based on the fact that women tend to marry much earlier than those of men, while their reproductive years also end much earlier than those of men (women are likely to be in their menopausal years as from about the age of 50 years, while many African men still procreate even when they are over 70).

From the FGD discussions, it was generally said that the ideal roles reserved for husbands include, provision of food, clothing, shelter money, taking wife to hospital for treatment, ensuring good health for wives and providing drugs for wives during illness. In reality, both male and female FGD said husbands hardly carry out their traditional responsibilities and obligations with regard to their wives (see Table 6). Table 6 presents data from FGD sessions showing the common attitudes husbands display towards their pregnant wives. All FGD groups (male and female groups) expressed the opinion that men often fail to play obligatory roles at home. Sixteen (16) out of the 18 FGD expressed the view that men often fail to pay hospital bills, while 14 of the 18 FGD reported wife neglect during pregnancy, The FGD *Extract 1* speaks of the ideal role of a man in ensuring a good health for his wife, while FGD *Extracts 2 to 4* said that of total wife neglect was a common occurrence,

Extract 1: (Baseline FGD- Men >45 years at Ode Omu)

"It is the man's responsibility to take care of his wife. Whether she is sick or not, he should take care of her as long as she is his wife..... The husband must be vigilant about her health, if there is anything about her health which he cannot take care of at home, he must make sure that he takes her to the hospital".

Extract 2: (Baseline FGD – Men <45 years at Ode Omu)

"Many men in this town show love for their wives only when they want to have sex with them, What may happen later is none of their business. Most of the time, they quarrel over sex especially during pregnancy, and become angry if their wives refuse them. What they do then is hate such wives and refuse to take care of them. Many of our men desire 'children only"from their wives, they do not care to have any responsibility over them and their children."

Extract 3: (Baseline FGD- Female Opinion Leaders at Otan Ayegbaju)

"Men in this community see their wives a filthy rags.Their only hope and joy with them is sexual relationship. Once the wives are pregnant, they desert them till that time when they will be free for sex again ".

Extract 4:

"I remember the case of a woman leaving her husband on the grounds of neglect, There are many such cases like this in this community. It has become a routine experience"

On the whole, FGDs confirmed the knowledge that men have about pregnancy and pregnancy outcomes is not adequate (see Table 7). It is significant that all the FGDs in the baseline survey recorded this opinion (see Table 7). Table 8 equally confirmed that women have no control over their own sexuality (this was mentioned in all FGD sessions except one). Also 14 out of the 18 FGDs in the baseline survey recorded the opinion that "wives can't decide the number of children to have," while 14 FGDs remarked that "men have the last say" in matters relating to women's sexuality. In fact, 11 FGD said that "only free women have total control" on sexuality matters. Significantly, only very few FGD groups expressed the fact that "economic strength gives women some control" over their sexuality. This is to say that women need

more than mere economic empowerment to have some control over their own sexuality.

Although men who participated in the intervention phase are now better equipped with the knowledge of 'dos' and 'don'ts' of pregnancy, such men are still in the minority. The FGD extracts below throw more light on this.

Extract 5: (Post Intervention FGD: Men > 45 years at Ode Omu)

"What men know about pregnancy is grossly inadequate. This program has exposed a lot of us to more knowledge on pregnancy and pregnancy outcomes, especially the risks women face. But what of those under-age boys who just impregnate girls without giving any thought to pregnancy outcomes? Parents do not teach their male children about pregnancy and its outcomes. Unless we have periodic workshops on pregnancy such as this one, it might be difficult for men to have sufficient knowledge about pregnancy ".

Extract 6: (Post Intervention FGD: Male Opinion Leaders at Ejigbo)

"Current hospital programs for pregnancy care concentrate only on women, without much reference to men. If men are seen as agents of change and as important factors for improved pregnancy outcomes, they must show more commitment to the care of their pregnant wives".

To get men more involved in pregnancy care and improved outcomes, both women and men in the various FGD sessions prescribed important solutions. Popular suggestions made by the women's groups include (in order of popularity) (see Table 9) –

- Wives are to satisfy husbands sexually even while pregnant;
- Men's groups shoul br targeted for enlightenment programs;
- Husbands should participate in hospital based antenatal health talks;
- Husbands should be exposed to drama shows;
- Wives must show husbands love;

For male groups, the suggestions (in order of popularity) include (see Table 9)

- Respect husband as the head of the home;

- Show love to husbands;
- Educational films/drama sketches on pregnancy care
- Periodic seminars on women's reproductive health etc.

Although educational intervention programs introduced in the experimental towns tend to have a positive impact on the attitude of men and women towards pregnancy and its outcomes, men remain the most important actors in this area, and constitue a major agent of change. Women must therefore learn to satisfy their husbands, even when it is not confortable for them (women). For example, both male and the female FGDs highlighted the need to 'show love to husbands', 'respect him as the head of the home', and even 'satisfy their sexual desires even when pregnancy could make it less comfortable to women'. All these suggestions highlight the culture of male supremacy in homes, especially in life threatening situations such as emergency obstetric conditions.

CONCLUSION

This study is predicated on the assumption that the culture of male supremacy is the cause of the high prevalence of maternal mortality in most African societies. Men who are generally ignorant and often indifferent with regard to the conditions of their wives during obstetric emergencies are culturally empowered to take all decisions with regard to sexual relations and childbearing. In addition to the obligation for women to seek permission from their husbands before attending health care centres, the society further imposes on women taboos that must be adhered to during pregnancy. These for instance, include food taboos. Unfortunately, the forbidden food items are usually nutritive foods that could enhance viable foetal development. Both men and women in the study area were interested in high fertility, with a general preference for male children.

Poverty contributed to high maternal deaths also. Most men were unable to foot hospital bills for their wives, and therefore discouraged them from attending modern health care centers.

Instead their wives were routinely sent to traditional healers. In fact, many of these wives went to hospital only when their condition became critical or as was more often the case complicated. In many cases, a large number of pregnant women remained *uncared* for even in emergency cases. To many husbands, the cost of diagnostic tests and drugs was too high and thus unaffordable.

Even though it was observed that men were genuinely ignorant of pregnancy conditions requiring emergency care they were the ones who decided when a woman should be pregnant, where she should receive treatment during pregnancy, and where she should deliver the baby. This obvious oppression of women needs to be stopped; they should be given more rights with regard to childbearing and their own sexuality. Although some changes were noted in the experimental towns (Ejigbo and Ode Omu) compared with the control town (Otan Ayegbaju), the deep-seated patriarchal arrangements and gender role relations would need intensified enlightenment and mobilization programs to establish more equitable condition of partnership and cooperation in homes. To achieve this, it may bacome necessary to integrate reproductive health and gender related issues into mass literacy and population education programs and health policies. The present power imbalance in homes is no doubt a result of the control that men have over productive resources, since women are generally denied the right to private property. Women's right to private property is intricately linked to cultural rights and demands. Unless traditional cultures become more receptive of contemporary demands and innovations, women might forever be denied the right to choose life.

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KEY TO FGD TABLES

SYMBOLS	*KEY*
<35	FGD group made up of under 35 years
<35	FGD group made up of over 35years
<45	FGD group made up of under 45 years
<45	FGD group made up of over 45 years
OD	Odeomu (the experimental town)
OT	Otan Ayegbaju (the control town)
EJ	Ejigbo (an experimental group
FOP	FGD group made up of female opinion leaders;
MOP	FGD group made up of male opinion leaders

Table 6: Common attitudes of husbands towards their pregnant wives

Men's Attitude	FEMALE FGD GROUPS								MALE FGD GROUPS								
	<35 OD	<35 OT	<35 EJ	<35 OD	<35 OT	<35 EJ	FOP OD	FOP OT	FOP EJ	<35 OD	<35 OT	<35 EJ	<35 OD	<35 OT	<35 EJ	MOP OD	MOP OT	MOP EJ
Often fail to meet obligatory roles at home	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
They are often absent from home	-	+	+	-	+	+	-	-	+	+		+	+	+	+	-		+
Do not follow wives to clinic	-	-	+	-	+	+	+	+	+	+	+	+	-	-	-	-	+	+
Wife battering during pregnancy	-	-	+	+	-	+	-	-	+	-	-	-	-	-	-	-	-	-
Failure to pay hospital bills	+	+	+	+	+	+	+	+	+	+	+	+	+	+	-	+	+	+
Wife neglect during pregnancy	+	-	+	+	+	-	+	-	+	+	+	-	+	+	+	+	+	+
Neglects wife if he feels sexually starved	-	-	-	-	-	+	+	+	+	-	+	+	+	+	-	+	+	+
They feel culturally permitted to be polygynous	+	-	-	-	+	+	+	+	+	-	+	+	+	+	+	+		+
Educated men take more care of their wives	-		-	-		+	+	+	+		+	+	+	+		+	+	+

Key: + Where the FGD group expressed a particular opinion

\- Where the FGD group did not express a particular opinion

Table 7: Knowledge about pregnancy and pregnancy outcomes

	FEMALE FGD GROUPS									MALE FGD GROUPS								
Response	<35 OD	<35 OT	<35 EJ	<35 OD	<35 OT	<35 EJ	FOP OD	FOP OT	FOP EJ	<35 OD	<35 OT	<35 EJ	<35 OD	<35 OT	<35 EJ	MOP OD	MOP OT	MOP EJ
Inadequate	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Adequate but not committed	-	-	+	-	+	-	-	-	+	+	-	-	-	-	-	-	-	-

KEY: + Where the FGD group expressed a particular opinion

\- Where the FGD group did not express a particular opinion

Table 8: Extent of the control women have over their own sexuality

Extent of control	FEMALE FGD GROUPS									MALE FGD GROUPS								
	<35 OD	<35 OT	<35 EJ	<35 OD	<35 OT	<35 EJ	FOP OD	FOP OT	FOP EJ	<35 OD	<35 OT	<35 EJ	<35 OD	<35 OT	<35 EJ	MOP OD	MOP OT	MOP EJ
No control	+	+	-	+	+	+	-	+	+	+	+	+	+	+	+	+	+	+
Wife can't decide the number of children to have	+	+		-	-		-	-		+	+	+		-	-	+	+	+
Men have the say	+	+	+	-	-	-	-			+	+	+	-	-	-	+	+	+
Only free women have total control	-	-	-	+	+	+	+	+	+	+	+	+	-	-	-	+	+	+
Economic strength give's women some control	-	-		+	+	+	+	+	+		-	-	-	-		-	-	-

KEY + Where the FGD group expressed a particular opinion

\- Where the FGD group did not express a particular opinion

Table 9: How to encourage men to take care of their pregnant wives

Response	FEMALE FGD GROUPS									MALE FGD GROUPS								
	<35 OD	<35 OT	<35 EJ	<35 OD	<35 OT	<35 EJ	FOP OD	FOP OT	FOP EJ	<35 OD	<35 OT	<35 EJ	<35 OD	<35 OT	<35 EJ	MOP OD	MOP OT	MOP EJ
Being a good wife	+	-	+	+	+	+	-		-	+	+	+	+	-	+	-	-	
Accepting husbands as heads	+	+	+	-	-	-		+	-	+	+	+	-	-		-	-	-
Wife to consent to husbands sexual desires in pregnancy	+	-	-	+	-	+	-	-	-	+	-	+	-	-	-	+	-	-
Keeping husbands informed of progress in pregnancy	+	-	+	+	-	+	+	-	+	+	+	+	-	-	-	+	-	+
Wife takes care of appearance to remain attractive	+	+	+	-	-	+	-	-	+	-	-	-	-	-	-	+	-	-
Pregnant wife to prepare good food	+	+	+	+	-	-	-	-	-	-	+	+	-	+	+	-	-	-
Tolerate wife's poor health in pregnancy	+	-	+	-	-	+	-	-	-	+	-	+	-	-	-	+	-	+
Wife to show love to husband	+	-	+	+	+	+	+	-	+	-	-	+	-	-	-	+	-	+
Wife to make home clean	+	-	+	-	-	-	+	-	+	-	-	-	+	-	+	-	-	+
Caring attitudes from wives	-	+	+	-	-	-	+	-	+	-	+	-	-	-	+	+	-	+
Educate husbands more on women's reproductive health	+	-	+	-	+	+	+	-	+	-	-	+	+	-	+	-	-	+
Public enlightenment with special focus on men	+	-	+	-	-	-	+	-	+	-	-	+	-	-	+	+	-	+

KEY + Where the FGD group expressed a particular opinion

\- Where the FGD group did not express a particular opinion