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## Male Role in Emergency Obstetric Care in Rural Niger Delta, Nigeria

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### **Abstract**

*After more than two decades of continuous democratic rule and government policies geared towards improved emergency obstetric care (EmOC) access in Nigeria, maternal mortality remains a fundamental public health challenge. Although many studies have emphasized the significance of the male role in female reproductive health-seeking behavior in the country, there is insufficient empirical evidence on the male role in accessing EmOC in Nigeria's Niger Delta region, the bastion of the nation's petroleum industry. This study explored women's perspectives, beliefs, and experiences concerning the role of their husbands on reproductive health by collecting quantitative and qualitative data in an economically disadvantaged community of Bayelsa State. A semi-structured questionnaire was administered to 616 women aged 15-49 years. Focus Group Discussions (16) were conducted among purposively selected male and female participants. Men play positive roles toward accessing EmOC by women in rural Bayelsa. At least eight out of ten women reported that their husbands were present during pregnancy or birth complications; five out of ten claimed they followed them to hospitals or clinics for treatment. Men also provided the finance for the specialized care during emergencies. This study provides empirical evidence of a positive male role in accessing EmOC in the study area. More deliberate promotion of male involvement in the reproductive health of their wives will contribute significantly to the reduction of maternal mortality in a patriarchal society such as Bayelsa.*

**Keywords:** Male role, Emergency Obstetric Care, maternal mortality, Niger Delta, Bayelsa

### **Introduction**

Maternal mortality has shown uneven burden and progress globally (World Health Statistics 2021). While the global maternal mortality ratio (MMR) estimated a decline of 35% between 2000 (MMR of 342) and 2017 (MMR of 211), the sub-Saharan Africa (SSA) region has the highest maternal death burden

with an MMR of 542 (World Health Statistics, 2021). According to recent estimates from World health statistics (2021), Nigeria is among the four countries with the highest burden of maternal mortality, with an MMR of 971, which is about four times the average global estimate. This is regardless of a series of governmental policies and programs to reduce maternal morbidity and mortality, including improving access to emergency obstetric care (EmOC) at different levels of health care provision in the country.

One of the reasons for the difficulty of current policies and programs in achieving the Sustainable Development Goal 3 (SDG 3), reducing the maternal mortality ratio to less than 70 per 100,000 live births, in a patriarchy and pronatalist society like Nigeria, is the inability to recognize and incorporate the implicit role that men play in reproductive health (Isiugo-Abanihe and Obono, 2011; Isiugo-Abanihe, 2003; Obono, 2003, 2000). Reproduction in sub-Saharan Africa is reinforced by the pronatalist belief system regulated by patriarchal ideological structures (Caldwell and Caldwell, 1987; Ocholla-Ayayo, 1997; Obono, 2002 and 2003). This functional prerequisite “takes place within the context of complex social organization and under the influence of multiple social, cultural, and ideological realities” (Isiugo-Abanihe, 1994a, p. 237). In this context, the fertility of individual women reflects mainly the preferences of the men. The biases created and reinforced by patriarchy extend male dominance over women’s health, including reproductive health, where their decisions are regarded as final (Isiugo-Abanihe, 2003; Nwokocha, 2008). Patriarchy as a system fosters the total dependency of women on men in the family which include issues around conception, number of children, antenatal and postnatal care (Nwokocha, 2008).

Male reproductive motivation underpins fertility in African societies (Isiugo-Abanihe, 1994b; Obono, 2002, 2003). This is because the enormity of male role responsibility in female reproductive health-seeking behaviours, especially among the rural populace, has contributed considerably to women's prevailing poor health status. According to Isiugo-Abanihe (2003, p. 8), the characteristic lack of male involvement in reproductive initiatives is a significant obstacle in sub-Saharan Africa, given the considerable authority and power vested on men as decision-makers in the home and society. Therefore, there is a need to capture the nexus of the male role on access to EmOC for more clarity on the phenomenon of maternal mortality in contexts where men dominate decision-making on reproductive health.

Fertility, especially in countries with a high regime such as Nigeria, exposes women to reproductive health problems – the risk associated with pregnancy and childbirth-related complications – that promote maternal mortality. In Africa, tacit male control of maternal health practices remains a bane to achieving desired safe motherhood behaviours that considerably reduce maternal morbidity and mortality. Writing about the maternal crisis on the continent, Nwokocha (2008) observed that most men in Africa are indifferent to reproductive health. Such attitude in a male-dominated society implies that activities that influence maternal outcomes are taken for granted, ultimately resulting in maternal crises typical of the situation in Africa. The pervasive nature of patriarchal elements on

the African continent continues to produce and reproduce age-long relationships (Sen *et al.*, 1994) that subjugate women under men (Barrett, 1988) even when the former life is at stake. The study by Orji *et al.* (2007), corroborating Stock (1983), also reveals that in the face of the emergency obstetric situation, women mostly wait for their husbands to decide the course of action, implying that male authority structures are dominant even in emergencies. This has profound consequences for access and timely use of EmOC and maternal health outcomes.

Within Nigeria's Niger Delta region, the bastion of the petroleum industry, the available MMR estimate show that 918 out of 100,000 women die of maternal related causes in Bayelsa State (Bayelsa Strategic Development Plan, 2010). It is a largely rural state, with about 67 per cent of the population living in villages of less than 1,000 people. Onorkerhoraye (1999) observed that compared to other regions, medical healthcare facilities in Niger Delta, particularly in Bayelsa, are relatively poorer and inequitably distributed within the state. About 70% of skilled birth attendants, and most of the available functional health facilities, are located in the state capital and three out of the eight local government areas (LGAs) in Bayelsa State. The situation has been aggravated by prolonged political and civil unrest in the area in the last two decades. Moreover, the peculiar environmental and topographical terrain of Bayelsa, characterized by poor transport and communication means (Ikporukpo, 2002; Nwokocha, 2004) poses a formidable barrier to accessing emergency obstetric care.

Emergency obstetric care has been identified as a fundamental approach to reducing maternal mortality, particularly in developing countries, and more significantly in economically restrained enclaves characterizing Bayelsa State. Socio-cultural factors also contribute to the physical and health service hindrances to accessing EmOC in the state. However, the cardinal factor is patriarchy, strongly manifesting itself in male dominance in the society and their control of productive and reproductive activities of women, including the use of health care facilities and access to EmOC. Hence, achieving any substantial reduction in maternal mortality in settings like rural Bayelsa implies understanding and giving adequate attention to the role of men in the reproductive health of women.

Several studies on the male role in safe motherhood practices are in the Nigerian reproductive health literature (Isiugo-Abanihe, 2003; Nwokocha, 2004; Orji *et al.*, 2007; Lawoyin *et al.*, 2007; Nwokocha, 2008). Most of these studies focused on the importance of men in contraceptive behaviour, reproductive health issues relating to ante-natal care and preferred place of delivery, and perception of maternal mortality. Also, most of these were conducted in urban centers or semi-urban areas, mainly outside the Niger Delta. Empirical studies within the region are mostly hospital-based (Ibrahim *et al.*, 2012) with little emphasis on the male role in maternal health practices, including access to EmOC. This creates a knowledge gap in understanding factors associated with the health situation of the population, and in particular, the reduction of maternal mortality and improved female reproductive rights and behaviour in the riverine and swampy environment of Bayelsa State.

### **Methods and data**

The data for this study were extracted from a larger data-set for a PhD thesis on Access to Emergency Obstetric Care and Maternal Mortality in Rural Communities of Bayelsa, Niger Delta. The study was cross-sectional, using mixed methods of data collection. For the quantitative data, an interviewer-administered questionnaire was given to eligible women in survey research. A multi-stage sampling approach was employed; four local government areas (LGAs) were selected based on (1) existing information (Onokerhoraye, 1999; UNDP, 2006), (2) availability and location of health facilities, and (3) terrain of Bayelsa. The communities within each LGA were clustered based on 2006 census figures, and four communities each were randomly selected from each cluster in the LGAs, making 16 communities. Households were systematically selected in each community. The respondents were randomly selected; when two eligible women were in a household, the next birthday method was used to select one respondent. A total of 616 women of childbearing age 15-49yrs were interviewed using the Access to Emergency Obstetric Care and Maternal Mortality questionnaire.

The qualitative data were collected from sixteen Focus Group Discussion (FGDs) sessions: 12 female FGDs and four male FGDs. The discussion was on factors influencing access to EmOC, including a male role in EmOC. The female FGDs comprised four groups of women between age 25 and 35 years, five groups of women aged 33-49 years, and three groups of women aged 50 years and above. The FGDs among men involved two groups of males between age 30 and 40 years, and two groups aged 40-60 years. The minimum number of participants in a session was six, and the maximum eight. The quantitative data were processed and analyzed using SPSS version 16, while the FGD data were organized thematically using Atlas ti 6.

### **Results**

Table 1 displays the background characteristics of the respondents. The median age of the respondents was 28 years, with more than 72 percent in the 20-34 age group, reflecting the prime age of childbearing in Bayelsa. An overwhelming majority of the respondents were Christians, indicating that Bayelsa is predominantly a Christian State. About 43 percent of the women were in a cohabitation arrangement, a culturally accepted conjugal union among the Ijaw ethnic group (George, 1992). Another 40 percent were married, and six percent were separated, divorced or widowed. The study respondents comprised a highly literate population, with only 5 percent not attending formal schooling. Forty-nine percent had secondary education and above. Two-thirds of the women were currently employed, though half of them earned less than the national minimum wage of N18,000.

All the women in the FGD sessions were married, divorced or widowed, and had children. The major occupations among these women were farming and fishing. Similarly, all the men in the FGD sessions were fathers and farmers except a few civil servants.

**Table 1: Background characteristics of respondents, percent distribution**

Characteristics	Frequency	Percentage
<b>Age in group</b>		
15-19	42	7.3
20-24	111	19.3
25-29	137	23.8
30-34	110	19.1
35-39	93	16.1
40-44	46	8.0
45-49	37	6.4
<b>Religion</b>		
Christianity	561	97.9
Islam	3	0.5
Traditional	9	1.6
<b>Marital Status</b>		
Single	67	11.3
Co-habiting	256	43.1
Married	236	39.7
Separated/Divorced	26	4.4
Widowed	9	1.5
<b>Educational Attainment</b>		
None	25	5.0
Primary	229	45.8
Secondary	203	40.6
Tertiary	43	8.6
<b>Currently Employed</b>		
Yes	373	65.6
No	196	34.4
<b>Total Income</b>		
Less than 18,000	70	50.0
18,000-49,999	51	36.4
50,000-99,999	13	9.3
100,000 and above	6	4.3

**Men's knowledge of obstetric complications**

One key factor in accessing emergency obstetric care (EmOC) is knowledge of obstetric complications. Studies have shown that women's propensity to access EmOC is incumbent on knowledge of obstetric complications (Thaddeus and Maine, 1994; Doctor *et al.*, 2013), knowledge of the danger and critical signs in pregnancy, delivery and post-delivery periods. Thus, knowledge of these complications by men become essential to their role in emergency obstetric care (Iliyasu *et al.*, 2010; Alam *et al.*, 2014). FGDs participants were asked about men's knowledge of obstetric complications to explore these issues. It was evident from the responses of the male discussants that they were knowledgeable about obstetric complications faced by pregnant women. The male focus group discussion sessions mentioned several illnesses and obstetric

complications in women during pregnancy, delivery or after birth. For instance, the responses in the FGD in one of the communities include:

*“they suffer from malaria and typhoid.” (male, 38years)*

*“some women, after two or three months of pregnancy start bleeding.” (male, 47-years)*

*“some even run mad after delivery, and some have swollen legs.” (male 42 years)*

Also, male FGD participants mentioned complications, including bleeding and convulsion. Others mentioned health problems encountered by women during pregnancy include Malaria, epilepsy, weakness of the body, headache, bleeding due to much drinking in pregnancy, convulsion during delivery.

The study further explored the perception of rural Bayelsa women about male knowledge of obstetric complications. It was rather unforeseen that women generally believe that most men, if not all, know the complications of pregnancy, delivery or after birth. However, some women believe that men have knowledge of pregnancy-related complications but lack the specific knowledge of what to do. In the words of a 33-year old female participant: “They may have the knowledge, but do not know what to do in cases of complication.” The overall perception is that men in rural communities of Bayelsa have the necessary knowledge of obstetric complications. This has implications for their role in the family decision-making, financial support, emotional support and presence at home in critical times, all of which are considered crucial in access to emergency obstetric care, when necessary, in such enclaves where the people live.

#### ***Male role and decision-making dynamics on access to EmOC during Emergency***

The study further explored experiences relating to male role or actions during pregnancy complications or childbirth. The questionnaire elicited women's information regarding their last episode as presented in Table 2. The findings indicate that men played considerable roles in their wives' or partners' access to EmOC in the event of an obstetric emergency. A large majority of the women (82%) affirmed that their husbands supported them when they were ill from pregnancy or had complications; 86 percent claimed their spouses were present during their complications. A little more than one-half of the women (56%) indicated that their men followed them to the place of treatment, and close to 50 percent of the men who did not accompany their wives went to the facility to meet them later. Male cooperation was also evident in the small number of men (about 14 %) who decided the facility their spouses visited. This implies that Bayelsa women had relative freedom to choose the hospital

or clinic they considered most adequate for their condition with little male interference.

**Table 2: Percentage of women who reported roles played by their husbands in accessing Emergency Obstetric Care**

<b>Issues on Male Role and Access to EmOC (multiple responses)</b>	<b>Percentage</b>
Husband support you when you fall ill during pregnancy, delivery and after	82.1
Husband present during complication(s)	86.1
Husband accompanied wife for treatment	56.1
Husband came to the hospital later	46.9
Husband decided the place of treatment	13.6
Husband provided finance for treatment	79.4

The female FDGs further probed the issue of the male role in emergencies or pregnancy complications. In general, the responses corroborated our findings above. Most women who had experienced complication affirmed that their husbands were around when it started. The responses are indicative as observed in one of the discussions:

I was 6 months pregnant when I started experiencing bleeding. It came slowly and after sometime, it became serious. On that day, my husband was at home; I informed him and he accompanied me to the hospital in the next village.... We went by boat and luckily, there was a doctor (Corp member) and nurses on duty. They attended to me.  
(Female, 27-year old)

Similarly, a 35-year old female participant said:

I had delivered at home, but my placenta would not come out and I was bleeding seriously. My husband who was not around when my labour started had come home because I called him. Seeing that I was getting weak from bleeding, he rushed me to the cottage hospital in our community.

The choice and decision about place of treatment in the event of an obstetric emergency have been reported as one of the critical delays associated with access and use of EmOC and maternal mortality (Maine, 1993; Cham *et al.*, 2005). The need for women to contribute in the decision-making regarding their reproductive health has also been stressed (Heise *et al.*, 1999). However, only 14 percent of the cases did the husband decide where to go for treatment. Further exploration of the data reveals that a quarter of the women decided on the place to go for treatment during an obstetric emergency; the majority of the women (53 percent) jointly decided with their husbands/partners the place of treatment during such situations. Regardless of the facility chosen for

treatment, the husbands/partners generally provided the financial requirement to access such services, except on a few occasions.

The responses of women in the FGDs corroborated these findings. In a particular community, all the women affirmatively answered that men jointly decide with their wives the treatment facility whenever there was a complication of pregnancy or childbirth in consultation with their wives. One of the female participants opined:

Most of the men decide the place of treatment with their wives in cases of emergency, such as hard labour or bleeding. They discuss and decide with their wives where they would go sometimes before that kind of situation occurs. My husband and I discussed it, but some couples don't. (45 years old)

Also, even though some women said their husbands provide financial support occasionally, the consensus was that men always offer financial support when seeking treatment for emergency complications. Another participant in the female FGD mentioned this as others nodded in agreement.

For me, I had a problem in my last pregnancy that resulted in my stomach swelling up. My husband had to take me to hospital in Yenagoa (State Capital), even to Glory Land Hospital (an expensive private hospital) to have a scan. My husband spent N20,000. At Glory Land Hospital, he bought drugs that cost him N18,000. This is a lot of money and shows that some men do care. (28 years old)

While some participant expressed the same view about male prerogative in matters relating to decision-making, there are divergent views on payment for services in the event of an obstetric emergency. A 32-year-old female participant suggested that it was men's prerogative to decide on the place of treatment during obstetric emergencies and payment for services, even though significant others might assist. According to her:

Husbands and people around (relatives) can suggest the place of treatment. In summary, pregnant women will prefer to go to the hospital. Where the man does not have enough money, the wife and others can help.

In the same discussion group, another 48-year-old woman, using her personal experience, averred men do not always pay for their wives' treatment. According to her:

Some men do while some don't. The men here do not always assist their wives. The women sometimes pay for their treatment alone.



They save money from their farm and fish sales in case anything happens. That was what happened to me. (*female, 48 years*)

However, some female participants in another community agreed that men pay more often than not for medical treatment when their wives suffer complications during pregnancy or childbirth. The opinion of the men was also sought on the decision-making process concerning treatment during complications and the use of cesarean section emergency obstetric care. Most men would independently decide the place of treatment in such instances, although the extent to which men's ego were at play here could not be determined. A male respondent from a community responded:

It is the husband that determines where to take the wife. It depends, if she delivers at home or with the local midwife, there may be a serious problem. We take her to the hospital here or to the one in ..., the general hospital. It is the man who decides, not his family or the wife because she is not well. (*male, 46 years*)

In other words, men might decide when the woman is seriously sick and could not make the decision. Another man from the same community emphasized the prerogative of the man to make such decisions:

If the man opts for a traditional birth attendant, they will take her there. If he says otherwise, either a traditional healer or the hospital, the woman will be taken there for treatment. (*male, 42-years*)

The men believed that a marital contract confers the right of decision making on the husband. Asked if men who impregnated a woman without being married to her have the same right to make such decisions as men who were duly married, there was a general agreement that men always have the responsibility of making family decisions. This was succinctly captured by one of the male participants reflecting, perhaps, a male chauvinistic attitude:

Yes, he has the right to determine so long as he has impregnated the woman. He is married to her already. (*Male, 45 years*)

Table 3 shows a bivariate association between the socio-demographic characteristics of women and male supportive role in access to EmOC in rural communities of Bayelsa. The variables include the age of the women, education, employment status, years of marriage and type of union, and age at first marriage. Age of women, educational attainment, duration of marriage and age at marriage have a positive association with a supportive male role during pregnancy emergencies. Also, women in monogamous unions were more supportive of a positive male role than polygyny unions. Overall, more than 80 percent of the women positively evaluated men's contribution during emergency obstetric conditions, including being present, deciding on an appropriate facility, taking the women to a facility and paying the bills. This

was in agreement with the general views of men during the FGDs as discussed above.

**Table 3: Bivariate association between women's socio-demographic variables and male participation in EmOC**

Socio-demographic Characteristics		Husband supportive role in EmOC (%)	
		Yes	No
<b>Age of Women</b>	Below 20yrs	70.0	30.0
	20-24yrs	81.4	18.6
	25-29yrs	88.0	12.0
	30-34yrs	84.6	15.4
	35-39yrs	81.0	19.0
	40 and above	85.4	14.6
<b>Educational Attainment</b>	No formal education	76.4	23.6
	Primary	83.0	17.0
	Secondary	83.7	16.3
	Tertiary	80.6	19.4
<b>Employment Status</b>	Currently employed	84.0	16.0
	Unemployed	84.8	15.2
<b>Length of Marriage*</b>	1-2	66.7	33.3
	3-5	89.6	10.4
	6-10	81.8	18.2
	Above 10yrs	85.8	14.2
<b>Age at First Marriage</b>	Below 20	80.5	19.5
	20-24yrs	86.3	13.7
	25-29yrs	80.4	19.6
	30-34yrs	80.0	20.0
	35 and above	100.0	
<b>Type of Marital Union</b>	Monogamy	83.3	16.7
	Polygamy	77.8	22.2

\* *Chi-square test of association is significant at  $p < 0.05$*

### Discussion

Studies in Nigeria have demonstrated that men's knowledge of obstetric complications during pregnancy and delivery danger signs is poor (Lawoyin *et al.*, 2007; Sekoni and Owoaje, 2014). The findings from group discussions in this study demonstrated otherwise. In part, this is probably a function of the activities of non-governmental organizations, many of which initiated reproductive health programmes in different parts of the state in the last two decades. The overall perception is that men in rural communities of Bayelsa have the necessary knowledge of obstetric complications. Unarguably, such knowledge has implications for their role in decision-making and financial

support considered crucial in timely access to emergency obstetric care when necessary.

A large majority of the women affirmed that their husbands were present when their complications started; a little more than half indicated that their men followed them to the place of treatment and were responsible financially for their treatment. The cost of accessing health care in rural communities is relatively exorbitant, considering that the major occupations in these communities are farming and fishing for both men and women. The choice and decision about the place of treatment in the event of an obstetric emergency and the importance of women's contribution in the decision-making process regarding their reproductive health (Maine, 1993; Cham *et al.*, 2005; Heise *et al.*, 1999) are central to timely access to emergency obstetric care and reduction of maternal death. The majority of the women in this study make joint decisions with their husbands/partners on the place of treatment during obstetric emergencies is a positive development given the rurality of the study communities. Such a positive health-seeking behaviour will manifestly improve maternal health outcomes.

Past government programmes aimed at reducing maternal mortality in Nigeria, such as Midwife Service Scheme (MSS), Subsidy Reinvestment and Empowerment Programme (SURE-P) funded Maternal Child Health Programme (MCHP), and National Health Insurance Scheme (NHIS) pilot project on Millennium Development Goal/Maternal and Child Health Project, all ignored to make male role in maternal health, particularly emergency obstetric care, one of its principal targets. Consequently, the primary objectives of these programmes to reduce maternal and child deaths were undermined, and maternal mortality remains unacceptably high, especially in rural Nigeria. Ignoring the male role in designing and implementing the programmes mentioned above stems from a stereotypical view of the male role in reproductive health (Isiugo-Abanihe and Obono, 2011).

However, for any meaningful and sustainable achievement in reducing maternal mortality through access to emergency obstetric, especially in economically restrained communities, men should be fully integrated into such initiatives. This is because "the socialization process makes Nigerian men influential and dominant in all spheres of life ... they are at the center of decision-making in the traditional political economy and important agents of change" (Isiugo-Abanihe, 2003, p. 133). This study has demonstrated that rural Bayelsa men are knowledgeable about women's health issues and are ready to partner with their spouses to provide and maintain good health care status, including full support in emergency obstetric care. Expectedly, over time this will give rise to a lower maternal mortality rate in the state and lower infant and child mortality.

## **Conclusion**

Knowledge and acceptance of the male role in accessing emergency obstetric care is considered critical to reducing maternal mortality, particularly in economically restrained rural communities as in Bayelsa. This study provides empirical evidence of a positive male role in access to EmOC in the study area. The findings from the survey and focus group discussion sessions indicate that men contribute positively to women's access to EmOC in rural Bayelsa. Notably, men make decisions either solely or jointly with their wives on the place of treatment; they provide the finance and follow the women to receive specialized care during emergencies. In a traditionally patriarchal society, as in Bayelsa, a more deliberate promotion of male involvement in the reproductive health of their wives will contribute hugely to the reduction of maternal mortality.

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