Maternal Crises and the Role of African Men: The case of a Nigerian Community

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ABSTRACT

Studies have consistently shown that maternal processes in Africa are prone to crises as a result of multiple socio-economic and religious factors. A combination of male-domination, low status of women, poverty, cultural beliefs and practices and high fertility affects pregnancy outcomes in most societies in the continent and especially in sub-Saharan Africa. With very few exceptions, African communities are patriarchal and as such norms, values and expectations are defined and sustained by men in virtually all spheres of life. This paper, which focuses on the Ibani of Rivers State, Nigeria, examines the role of African men during maternal periods to establish that pregnancy outcomes will improve significantly when women are supported by their spouses at different stages of maternity. The study reveals that men do not play roles during pregnancy-postpartum processes that are significantly different from their normal activities because pregnancy is perceived as a normal condition, which does not require special attention. The results also indicate that pregnancy outcomes among the Ibani do not necessarily derive from spousal communication and gender discourse because 87.7 percent of women whose husbands were solely responsible for decisions on child spacing recorded more Type-1 outcome (mother and child survival) than those whose husbands did not. By adapting the present investigation to the systemic approach, a holistic analysis of a complex phenomenon like maternal outcomes was undertaken.

Keywords: maternal processes, pregnancy outcomes, patriarchy, systemic approach.

Background: African Culture, Men and Maternal Events.

Maternal events in Africa are prone to crises for several reasons. Women are subjected to repeated childbearing at short intervals either to satisfy their husbands' quest for large family size or as a means of adjusting to the very high infant morbidity and mortality in the continent. The situation is exacerbated by cultural beliefs and practices and poor medical system that hinder access and use of hospital facilities during emergencies. In some communities, women's socio-economic status is significantly low to enable them contribute meaningfully to family discourse. Consequently, men take sole decisions that affect members of their families. This exclusivity notwithstanding, it has been noted that a large majority of men in Africa are indifferent to reproductive health. The implication of such attitude, in a male dominated society, is that activities that influence maternal outcomes are taken for granted, ultimately resulting in maternal crises typical of the situation in Africa. This concern was expressed by Isiugo-Abanihe (2003) when he observed:

Before the current concern for male involvement began, reproductive health issues and services had become synonymous with women's reproductive health, and men were assumed to have no special interest in such matters. However, the tacit exclusion of men from active involvement in these issues represents a lack of appreciation of the social reality of daily living in most developing societies, particularly in Africa. Indeed, the characteristic lack of male involvement in reproductive initiatives, including family planning, is a major obstacle to a speedy fertility decline in sub-Saharan Africa given the considerable authority and power vested on men as decision makers in the home and society (Isiugo-Abanihe, 2003:8)

The above insight highlights the essence of male involvement in pregnancy outcomes. Male role, however, derives from patriarchy which defines activities of individuals in the society. Its influence is felt in virtually all aspects of human endeavor. In most societies, men dominate and in some cases absolutely control the interactions and actions of members of their families in virtually all spheres of social relationships, as of rule. Max Weber had a similar observation when he conceived patriarchy as a particular type of household organization in which the father dominated other members of an extended kinship network and controlled the economic production of the household (Barrett, 1988). The implication of such control is that the economic structure is significant in coordinating other structures within the social system. The present study examines these assertions through investigation of the Ibani of Rivers State, Nigeria which is a patriarchal society located in the Niger Delta region of the country.

Patriarchy seen in the light of wholesome inequity has been perceived as an over-arching category of male dominance (Barrett, 1988), a situation carefully sustained by men through ages (Sen *et al.*, 1994). While it has been claimed by some men that such gender relationship is responsible for peace at homes and the society generally, skepticism and suspicion about the genuineness of such assertion among women and the likely consequent breakdown in spousal/household communication can have indirect impact on maternal outcomes. The tendency is high for couples that lack confidence in themselves to seek assistance from other people. The consequence in the long run is that the intimacy and agreement that should necessarily follow decisions on family planning, pregnancy, prenatal and postpartum care are lost. Pregnancy outcomes then become events that result from *randomness.*

The pervasiveness of patriarchy as a system that does not discriminate against either patrilineal or matrilineal societies but conceived in terms of the difference in magnitude of its application to both societies has been highlighted. Gray (1982) argued that men are always in control of the myth system, even in matrilineal societies. Ottong expressed the same view when he stated:

The male plays a very dominant role in the social structure; he is, as of right, the head of the family, and is seen and regarded in certain circumstances by the wife (or wives) as the lord and master whose decision is always final. Even in the exceptionally few matrilineal societies, authority relations are still patriarchal, although patterns of descendancy and inheritance might be governed by the principles of matriliny (Ottong, 1993: 1).

Consciousness about the consequences of male dominance on women folk for the past few decades has been increasing and appears to be getting stronger by the day. Mill (1970) observed that the principle, which regulates the existing social relations between males and females, is not only wrong in itself, but also one of the chief hindrances to human development. She observed that such principle should be replaced by an alternative, which will be embedded in perfect equality, admitting no power or privilege on the one side, or disability on the other. Consensus among feminist and liberal writers on the negative implications of male dominance is evident (see also Nwokocha and Eneji, 2004). Patriarchy is viewed in some quarters as an institutional mechanism that serves to limit women's economic autonomy relative to men's. The result is that women unwittingly depend almost entirely on men, which has implication for the former's involvement in family decisions, including reproductive health, even when they are directly affected.

Studies have shown that socialization into sexuality and gender roles begins early in the family and community and are reinforced through the interplay of familial, social, economic and cultural forces, which are subsumed in patriarchy (Isiugo-Abanihe 2003; Moore and Helzner, 1996; Sen *et al.,* 1994; Obura, 1991). Similarly, Isiugo-Abanihe (1994a) maintained that cultural dictates shape behaviours; one's environment affects her reproductive attitudes, perceptions and motivations. Oke (1996) has observed that the use and non-use of health services are determined by one's socio-cultural environment, which, in most cases, is shaped by its patriarchal structure. Erinosho (1998) has also noted that many culture bound syndromes are effectively managed through an informed knowledge of their cultural contexts and the background of patients.

Some socio-cultural factors, which not only prevent women from getting out of their homes to utilize maternal health facilities, even in emergencies, but also prohibit them from eating certain foods, have been identified (Jafarey and Korejo, 1995). For instance, in parts of Nigeria, cultural taboos discourage pregnant women from eating some fruits, vegetables, rice and other high-calorie foods that ordinarily reduce susceptibility to diseases and malnourishment during the period (Mbugua, 1997). Most of these restrictions are given in order to sustain the myth surrounding a particular tradition or to emphasize the sacredness of a custom conceived as inviolable.

Among the Ibani of Rivers State, Nigeria for instance, pregnant women are prohibited/prevented from coming out of their homes, during the popular *Nwaotam* festival which lasts for up to 3 days, notwithstanding their conditions. It is believed among the people that pregnant women who sight the festival masquerade would inevitably incur the wrath of the *Ikuba* god. The implication is that women whose conditions are critical hardly receive emergency obstetric care during the period. Consequently, the number of maternal mishaps among the Ibani within the period of the festival might be higher than other times.

Furthermore, it has been pointed out that culture, which in most African societies is defined by men, determines habits related to food, which in turn has some implications for the health status of individuals in the community. Among the Ibani for instance, it is common to see men and women of various ages drinking locally made gin *etee-te* in the public. Pregnant women in their various trimesters are not restrained from such alcohol use. Invariably, men unwittingly support their wives' consumption of alcohol which increases proneness to pregnancy complications.

Hence, data on pregnancy outcomes related to drugs or alcohol exposure are relevant for a deeper understanding of the factors that influence people's behaviour considering medical concerns about the consequences of exposure

to alcohol for maternal outcomes. For instance, according to the Noah Health (2001), drinking alcohol during pregnancy can cause physical and mental birth defects. Report shows that no level of alcohol use during pregnancy has been proven safe. Each year, more than 50,000 babies are born with some degree of alcohol-related damage. Many women are aware that heavy drinking during pregnancy can cause birth defects, but many do not realize that moderate or even light drinking also could harm the fetus (Center for Disease Control 2003; Noah Health, 2001). The specific effects of alcohol at different trimesters have been pointed out by Ling et al. (1996); alcohol interferes with organogenesis in the first trimester while it leads to mental retardation and spontaneous abortions during the second. In the third trimester, alcohol is associated with significant depression of fetal growth. Other anomalies that are ascribed to toxic effects of alcohol on the fetus include spinal defects, congenital heart disease among others (Ling et al. 1996). Among the Ibani, the rate of alcohol (specifically local gin) consumption is very high among pregnant women. This attitude, coupled with inadequate health facilities, explains the high rate of maternal and infant mortality and morbidity among the people. A combination of these factors makes the choice of the Ibani, for the study, very appropriate.

Individual and communal values, norms and perceptions are noted as responsible for the persistence of some cultural and religious practices and demographic behaviour in Africa and other parts of the world (McQuillan, 2004). For instance, female circumcision, which is commonly practiced in Africa and Middle East, has been implicated in maternal deaths (Odebiyi and Aina, 1998). It has been observed that infection and obstetric complications that arise as a result of such practice place considerable strain on already inadequate health facilities (Odebiyi and Aina, 1998). Records show that female circumcision is widely practiced in 26 African countries, revealing the wide nature of the practice in the continent (Mbugua, 1997).

The foregoing highlights the role of male-dominated culture in shaping maternal health conditions and outcomes among individuals in sub-Saharan Africa. In addition, it has been pointed out that since over 60 percent of the population of Africa are rural based, cultural norms and practices still exert a strong influence on reproductive health care, especially in relation to pregnancy, delivery and child rearing. The implication is that women's contributions to maternal health are limited (Njikam, 1994). Such limitation affects maternal-outcomes generally considering that some of these women are compelled to observe culturally approved activities, even when they undermine their safety.

It has been observed that most women are beginning to emphasize the limiting capacity of their motherhood activities in relation to childbearing.

Grimshaw (1986), for instance, pointed out that motherhood has often been ideologically constructed in ways that have served to legitimize the dependence of women on men. Her position that motherhood annihilates women and should therefore for sometime be totally rejected re-echoes the position of most feminists that being a mother not only obliterate one's freedom but also a means to capitulate to patriarchy. But going by the African value that places premium on children, the emphasized limitation of motherhood is clearly contradictory. Moreover, the status of women in most societies in Africa is confirmed by their fertility and especially in having male children. Motherhood thus becomes an agonizing experience for women that have only female children and those that are infertile, in places where male-child-syndrome is emphasized (Nwokocha, 2007).

Framework for explaining the role of African men in maternal outcomes

Maternal events are characterized by a sequence of activities that influence results following pregnancies. This paper adopts the Systems theory which explains maternal outcomes as the cumulative effects of the stages that characterize the pregnancy-postpartum processes. The position of this theory is that the activity of any part of a whole affects the activity of every other part and the whole in general (Bertalanffy (1968). This implies that the impact of any stage of pregnancy affects in varying degrees, every other stage and the final outcomes. Onyeonoru (2000) observed that a system is portrayed as an entity made up of interrelated and connected parts. Rather than dealing separately with the various stages of pregnancy as unrelated entities, the systems approach views pregnancy as composed of interrelated and interacting stages. Systems of various orders are understood by investigating their respective parts as making a whole. This is irrespective of whether inanimate things, living organisms, or social phenomena are the objects of focus. By using the organismic analogy to explain the social system Bertalanffy noted:

It is necessary to study not only parts and processes in isolation, but also to solve the decisive problems found in the organisation and order unifying them, resulting from dynamic interaction of parts, and making the behaviour of parts different when studied in isolation or within the whole (Bertalanffy, 1968:31)

The implication is that analyzing each stage of the pregnancy-postpartum processes in isolation of others will only produce results related to these stages as separate subsystems. A different response is generated when their links are emphasized. The reason why literature on pregnancy outcomes is noticeably scanty is that individual scholars have been focusing on one or some aspects of the system and not all. Family planning, as an integral part of reproductive health, has received significant attention among scholars in

various societies. Its analysis, for most part, terminates at the point where conception either is prevented or occurs as desired. The closure of the limits of analysis of a subsystem from other units of analysis presents just a partial view of reality. The problem confronted by researchers as a result of such sub-systemic insulation is that knowledge is disarticulated and conclusions are extremely difficult to generate.

As shown in Figure 1, the systems theory asserts that understanding each stage in the pregnancy-postpartum continuum and its relationship with other stages is essential for a holistic analysis of pregnancy outcomes. In this wise, the factors that affect access and use of family planning methods are examined in order to investigate their impingement on pregnancy outcomes. The decision making process underlying family planning equally has implications for the timing of pregnancy and prenatal care. The likelihood is higher for couples that space births with at least two years interval to readily defray the cost of prenatal care than couples who give birth at shorter intervals, especially in a harsh economic environment. Also, depending on the level of agreement between couples on family planning dynamics, a husband might withhold or withdraw both financial and emotional support at various stages of pregnancy. The attitude exhibited by husbands at each of these integral stages (family planning, pregnancy, prenatal care, delivery and postpartum) of pregnancy affects the psychological disposition of women which is critical to maternal outcomes.

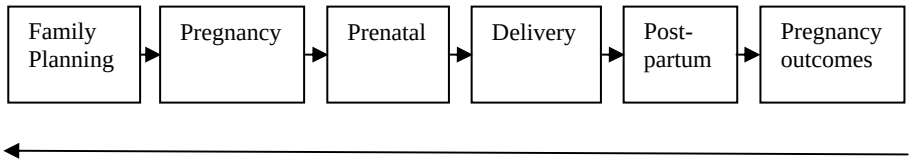

Figure 1: Pregnancy-postpartum Stages

At another level, systems theory emphasizes communication and feedback in the analysis of a whole. The implication of this analogy is that systems involve the stimulus–response relationship. In essence, input (cause) must precede output (effect). Feedbacks are necessitated by the effects recorded at the end of a sequence of activities. The need for feedback is in its ability to give some signal to the stimulus so that equilibrium is either maintained or adjustments are effected. In other words, there is a clear connection between inputs to the system and its performance (Stoner *et al*., 2000; Hodge *et al*., 1996; Griffin, 1993). This stimulus–response analysis involves examining pregnancy and pregnancy outcomes as events that are inextricably linked. Specifically, pregnancy and activities that affect outcomes such as family

planning, timing of pregnancy, prenatal care and postpartum services individually and collectively represent the stimuli that interact to produce the response – the outcome.

Methodology

The main study instrument was the structured questionnaire. The designing of the questionnaire schedule followed information generated from a pilot study through Focus Group Discussions (FGDs) and Unobtrusive Observation. The use of focus group for investigation in the present study was necessitated by the need to understand why Ibani people exhibit certain behaviours that affect pregnancy-outcomes. Importantly, considering that the inner motivations and emotional responses of the people to certain cultural features could not be established without employing an in-depth exploratory approach, FGDs were conceived as suitable for the study. The group sessions provided discussants the opportunity of explaining certain cultural beliefs and practices of the people in addition to facilitating their views on necessary adjustments to existing customs and tradition that could negatively impinge upon pregnancy outcomes. In the end, data emanating from these FGDs deeply revealed the people's situation, making the understanding of the perceptual and emotional complexities that affect the behaviour of the Ibani towards pregnancy and pregnancy outcomes very evident.

Five FGDs were conducted during the pilot stage of the study and the remaining sixteen, were conducted either slightly before survey research or concurrently with questionnaire distribution. Each FGD category included men and women who are of homogenous socio-demographic characteristics. Homogeneity among FGD participants bridges unnecessary social distance in the course of group discussions. This allows discussants freedom in giving information. To ensure inclusiveness, at least one FGD session was conducted in each of the 14 villages that make up Ibani society. A total of twenty-one sessions were conducted for the study.

Specifically, men were categorized into four groups (15-24, 25-29, 30-39, 40 and above) to capture the views of a cross-section of the people on cultural beliefs, values and practices including the roles they play during their wives' pregnancy-postpartum period. Among women, categories comprised three age groups (15-19, 20-49, 50 and above) of those that could have, are having and had had pregnancy-postpartum experience. From these FGDs, it was possible to comparatively assess the views of different age and sex groups over time that aided the designing of survey instrument.

Unobtrusive observation was one of the qualitative methods adopted for the study. The use of observation as a "passive" ingredient of the qualitative research technique is a consistent prerequisite for undertaking of culture-

related studies adequately. The influence of beliefs, values, customs, arts and the resulting practices – all subsumed in culture as a complex whole – on a people's behaviour need not be underestimated and can only be deeply appreciated by observing them uninhibited. It was observed *inter alia* that the Ibani are engaged in limited occupational activities; their very high rate of locally-made gin or *etee-te* consumption including among pregnant women was readily manifest and has relationship with low temperatures in this coastal environment; that health facilities are grossly lacking that the distance between virtually each of the villages to Ibani town is about the same and takes about 2 to 3 hours canoe ride.

Data collection through questionnaire began with a three-day training of field assistants and the concurrent pre-testing of survey instrument in order to ascertain its validity and reliability. These activities necessitated minor changes both in format and content of the questionnaire. In the end, questions were designed in open and close-ended form, and were also pre-coded. A cross-section of Ibani women age 20 – 60+ were selected as respondents using a multi-stage sampling technique.

Sampling started after obtaining a complete list of enumeration areas (EAs) in Ibani society from the National Population Commission (NPC). The study aimed at sampling about 14 percent of the total number of EAs through random technique in order to generate representative data. Twenty-two EAs were selected by first organizing the entire EAs into 14 clusters according to the villages that make up the society. The clusters were made up of an average of 11 EAs and about 10 percent of the EAs within each cluster were selected by simple random technique. A sampling frame of women who constitute survey respondents for the study was non-existent and it became expedient for the research team to devise a frame for households through a household census.

The next stage involved the use of systematic approach in the selection of households from the 22 EAs that had already been chosen. Within each selected household, an ever-pregnant woman was interviewed. However, where more than one ever-pregnant woman were found in a household, a simple random procedure (which allowed each of these women to pick a folded paper, with only one of them getting the piece that would qualify her as a respondent for the study) was adopted to select the one that was finally interviewed. In all, 750 questionnaires were administered out of which only 709 questionnaires were useable, representing a return rate of 94.5 percent.

Results and Discussion

In this section, maternal crises are examined in the context of negative maternal outcomes which stakeholders perceive as such. Such perception is central to understanding of pregnancy results due to conceptual ambiguity arising from varied meanings among different people. Consequently, classifying pregnancy outcomes as positive or negative (desired or undesired) may deepen the discrepancy; hence, these outcomes are described according to the expectations of individuals who have stake in such outcomes. A couple who for some reason do not desire a particular pregnancy might interpret spontaneous abortion as a positive outcome. A different interpretation may be given to the same outcome by another couple who have different fertility preference.

For the purposes of circumventing this ambiguity, four principal types of pregnancy outcomes were identified among the Ibani. Type-1 represents mother and child survival; Type-2 is synonymous with maternal survival but infant mortality; Type-3 means spontaneous abortion; and Type-4 is similar to maternal mortality but infant survival. These typologies are demonstrated in the analysis and discussion that follow. However, given that the study involved living respondents, the latter category (Type-4) was not applicable to the present analysis although it constitutes major maternal crisis globally. Apart from Type-1 which is hardly perceived as constituting crisis, the other types are mainly problematic especially in Africa where a high premium is placed on children. The role of men in family planning, prenatal, delivery and postpartum periods is critical to maternal outcomes as quantitative data indicate in the presentation that follow.

A total of 709 Ibani women aged 20 – 60+ were sampled for the study. The sample was sex-specific given the nature of the phenomenon under investigation and the fact that women are directly affected by pregnancy and subsequent outcomes. However, considering that pregnancy outcomes result from the interaction of both sexes, Ibani men were well involved in the qualitative aspects of the study. Table 1 shows that not all the respondents answered questions related to all the variables presented in the questionnaire. Some of the questions were conceived as sensitive and impinging on respondents' privacy and, therefore, were deliberately skipped by some individuals. The implication is that although a total of 709 respondents were involved in the quantitative study, less than that number responded to each of the variables

The sample has a mean age distribution of 46 years. This can be explained in terms of the socio-economic and environmental push factors that accelerate rural out migration. In the opinion of a male in-depth interviewee from Adongo Hart "what would young ladies be doing in the village where nothing

exists except gossiping; we encourage the youth to go out there and struggle with their mates".

Table 1: Selected Socio-Demographic Characteristics of Respondents

Characteristics	Categories	Frequency	Percent	Cumulative
Age	20-24	9	1.3	1.3
	25-29	32	4.5	5.8
	30-34	52	7.4	13.2
	35-39	49	7.0	20.1
	40-44	138	19.6	39.7
	45-49	153	21.7	61.4
	50-54	121	17.2	78.6
	55-59	82	11.6	90.2
	60+	69	9.8	100.0
	Total	**705**	**100.0**	
Marital Status	Single	15	2.2	2.2
	Married	563	80.8	82.9
	Cohabiting	4	.6	83.5
	Divorced	39	5.6	89.1
	Separated	21	3.0	100
	Widowed	55	7.9	97.0
	Total	**697**	**100**	
Education	No schooling	62	8.8	8.8
	Primary	240	34.0	42.8
	Secondary	385	54.5	97.3
	Tertiary	19	2.7	100
	Total	**706**	**100**	
Occupation	Civil service	59	10.3	10.3
	Fishing/farming	266	46.3	56.6
	Small trade	202	35.1	91.7
	Unemployed	34	5.9	97.6
	Others	14	2.4	100
	Total	**575**	**100**	
Age at first marriage	15-19	48	7.0	7.0
	20-24	320	46.6	53.6
	25-29	279	40.6	94.2
	30- above	40	5.8	100
	Total	**687**	**100**	

As regards the marital status of respondents, about 81 percent of the women are currently married, and only 2.2 percent are single. Nearly 8 percent of the women are widowed and another 8.6 percent are either separated or divorced.

The implication of this finding is that the level of marital instability among the Ibani is high relative to national figures which are less than 2 percent for widowed and separated/divorced (NPC, 2000). One of the male FGD participants in age-group 40+ noted:

It is not in our custom to force our daughters to marry … but we welcome genuine people that are introduced as would-be husbands by the girls. Marriage, on the other hand, does not suggest that our daughters no matter how bad they are treated cannot come back home and also be re-established to begin life anew … there are instances when such ladies, even at times after two or more attempts, later married men who are their real husbands (Wilcox. 19/06/02).

Neither separation nor divorce attracts stigmatization or strong disapproval by members of the community and re-marriage is common among the Ibani. Each marital union makes demands on couples in terms of child bearing, as defined by the pronatalist ethos of Ibani society. A male FGD participant stated: "although a woman may not be told out-rightly about the need to give birth to at least one child in her matrimonial home, she is, however, expected to win the heart of her husband by doing so". According to some community elders, marriage is not and should not mean that women are completely detached from their families, to the extent that even when they are seriously maltreated, they cannot come back home. The study found that marriage ceremony (endogamous and exogamous) among the Ibani is simple and the bride wealth is low relative to what obtains in many communities in the Niger Delta.

An examination of the educational qualification of respondents shows that considering the 54.5 percent as well as the 2.7 percent of respondents with secondary and tertiary education respectively, Ibani women are obviously literate. A woman's level of education is related to her ability to recognize symptoms of pregnancy associated complications, healthy nutrition during pregnancy and how and when to use contraceptives to control fertility.
Although Ibani women are literate, the majority of respondents are engaged in occupations other than civil service. The table shows that only 10.3 percent of the respondents are civil servants. Respondents are however not strictly separated along occupational lines, as depicted by the table. It cannot be completely asserted that activities are rigidly separated to the extent that individuals cannot criss-cross or switch occupations at the same period. Among the Ibani, most people that are engaged in farming and fishing, that could also be classified as unskilled laborers, are sometimes involved in small trade; hence, there is duality and at times, multiplicity of roles/occupations. As one of the female FGD participant in the 20–49 age category confirmed: "most of us that are involved in fishing also smoke them and eventually sale these fishes for a living".

The interaction of the respondents' educational, occupational and income statuses reveals that these variables are related to the age at marriage with the mean at 24 years. This average is normal in communities where strong significance is attached to higher education for both sexes. Engagement in educational activities affects age at marriage, increase an individual's occupational opportunities and income. The 7.0 percent representing those of ages 15–19 (although adolescents are meant to be eagerly committed to academic pursuit) shows that the number of Ibani women that married at those ages is low. When women marry very early, they usually leave school and often are dependent on their husbands. Moreover, research shows that pregnancy among adolescents carries heavy risks; pregnant women under twenty years of age are at greater danger of having pre-eclampsia (Chism, 1997).

Table 2 displays data on the cross tabulation of pregnancy outcomes with decision on child spacing which shows strong relationship at 1 percent significance level. As shown, 316 respondents indicated that decision on spacing is solely that of their husbands indicating a strong patriarchal culture. However, the patriarchal dominance among the Ibani does not seem to have adverse effect on pregnancy outcomes as is evident in Table 2 which shows that 87.7 percent of those whose husbands took decisions alone had Type-1 pregnancy outcome[1].

The success associated with such unilateral decision taking has implicitly sustained the subordination of women in most societies and accounts for high fertility (Kritz *et al* 2000; Isiugo-Abanihe 1994b). Ideally, the expectation is that joint decision making as an indication of effective spousal communication would result in more Type-1 pregnancy outcomes. According to Table 2, when decisions were jointly made, only 74.3 percent of the respondents in that category reported Type-1 outcome. Data presented for joint decision making stand at the middle of each of the sole ("husband's" and "own decision alone") decision making categories. At one extreme of the sole-decision making category are women alone, with 33.8 percent of them (jointly) recording Type-2 outcome[2] (26.8 percent) and Type-3 outcome[3] (7.0 percent), which is the highest of Types 2 and 3 outcomes for all the categories. This result can be attributed to over-dependence on men in the past by these women, which still accounts for their inability to effectively take sole decisions, as and when necessary. Thus, given that male dominance as a system of relationship took several decades to establish in most societies, it is equally necessary that female independence would take a gradual

[1] represents mother and infant survival
[2] mother survival but infant mortality
[3] spontaneous abortion

approach in its evolution in order for them to take both informed and effective decisions.

Table 2: Decision on Birth Spacing and Pregnancy Outcomes

	Pregnancy outcomes			
Decision Taker	Type-1	Type-2	Type-3	**Total**
My husband's decision alone	277 87.7%	23 7.3%	16 5.1%	316 100.0%
My own decision alone	47 66.2%	19 26.8%	5 7.0%	71 100.0%
Both of us	133 74.3%	35 19.6%	11 6.1%	179 100.0%
Others	2 15.4%	10 76.9%	1 7.7%	13 100.0%
Total	459 79.3%	87 15.0%	33 5.7%	579 100.0%
Pearson's Chi-square [df]	55.900[3]*			
Significance Value	0.000			

* Types 2.and 3 were merged for the chi-square analysis to improve the reliability of the test.

The last category in Table 2, are 13 respondents who are not directly affected by pregnancy outcomes as couples. For instance, pregnancy resulting from extramarital relationship can result in abortion. This state of affairs is both a justification and largely an explanation for 76.9 percent of respondents experiencing Types 2 and 7.7 percent recording Type-3 pregnancy outcomes (together making up 84.6 percent) against 15.4 percent that had Type-1 outcome. Also included in this category are those advised by medical practitioners, family members and friends on the need for birth spacing. In summary, 79.3 percent of the entire respondents had Type-1 outcome, while 15.0 and 5.7 percent of the total had Types 2 and 3 outcomes respectively. These data show that the incidence of Types 2 and 3 pregnancy outcomes among the Ibani is high.

Table 3 examines responses related to certain situations during which pregnant women took decisions concerning their health without the involvement of their husbands. The table shows that there is really an association between the variables at 1 percent significance level. Unlike Table 2 that reveals decision among respondents on spacing alone, Table 3 is not specific on when and for what reasons such decisions were solely taken. Beyond family planning, there are many situations in the pregnancy-postpartum processes that demand decision-making. For instance, where and when to begin prenatal care, how to manage the uncertainty surrounding

pregnancy related labour, the place of delivery and where postpartum care is perceived to be most effective.

As Table 3 shows, 86.3 percent of respondents who at one time or the other took independent decisions on maternal health had Type-1 pregnancy outcome, while 9. 2 and 4.5 percent had Types 2 and 3 outcomes respectively. These figures show that women who take independent decisions particularly on emergencies related to maternal health are much more likely to record Type-1 outcome than those who depend on their husbands for such decisions.

Table 3: Decision-Taking and Pregnancy Outcomes

Did you ever take some decisions about your health without your husband's involvement?	**Pregnancy outcomes**			
	Type-1	Type-2	Type-3	**Total**
Yes	421 86.3%	45 9.2%	22 4.5%	488 100.0 %
No	120 65.9%	42 23.1%	20 11.0%	182 100.0 %
Total	541 80.7%	87 13.0%	42 6.3%	670 100.0 %
Pearson's Chi-square [df]	35.264[1]*			
Significance Value	0.000			

* Types 2.and 3 were merged for the chi-square analysis to improve the reliability of the test.

Table 3 also indicates that 34.1 percent of respondents that never took independent decisions had Types 2 and 3 pregnancy outcomes with 23.1 percent and 11.0 percent respectively. It can be argued that most of these women may not have taken urgent decisions during emergencies leading to delays in seeking care. Research shows that late presentation of pregnant women with symptoms of complications to health facilities contributes to high maternal and perinatal mortality/morbidity. In sum, the nature of pregnancy outcomes are to a large extent related to how promptly decisions are taken at any point along the pregnancy-postpartum processes. The summary of Table 3 is that of the entire respondents, 80.7 percent had Type-1 pregnancy outcome, while 19.3 percent of the total jointly experienced Types 2 and 3 outcomes.

Table 4 shows the logistic regression model for pregnancy outcomes with respect to selected household characteristics. It shows that all the categories of the variable "decision on child spacing" are significant at the 0.05 level (95 percent confidence level). The variable "Husband's reaction to wife's single-handed decisions" shows an interesting pattern. It is significant at 0.01 level (99 percent Confidence level) when all its categories are taken together but when the categories are considered individually, only "Indifferent" and "Not aware" are significant at 0.01 level (99 percent confidence level).

For the variables: "type of role played by husband during pregnancy" and "person consulted on knowing about pregnancy", only the categories representing husbands who helped in household chores or consulted with parents respectively are significant at 0.1 level. The regression shows that husband's level of education is not related to pregnancy outcomes. The Model Chi-Square statistic shows a significance level of 0.01 (99 percent confidence level). The model predicts 88.6 percent of the responses correctly. The Hosmer and Lemshow Goodness of Fit Test's p-value of .193 confirms that the model's estimates fit the data well and at an acceptable level.

Table 4: Logistic Regression Model for Pregnancy Outcomes as a Result of Male Role during Pregnancy-Postpartum Period

Variables/Categories	**B**	**Sig.**	**Odds Ratio**
Husband's highest educational qualification		.707	
Primary	.386	.732	1.471
Secondary	-.085	.940	.918
Higher	- 5.853	.764	.003
No schooling	RC		1.000
Derivation of decisions on child spacing		.138	
Husband's decision alone	-3.064	.026	.047
Wife's decision	- 3.204	.028	.041
Husband and Wife's decision	-2.695	.049	.068
Others	RC		1.000
Husband's reaction to single handed decisions		.000	
Felt bad/sad	-.514	.310	.598
Indifferent	3.124	.000	22.734
Not aware	2.415	.002	11.194
He understands	RC		1.000
Type of role husband played during pregnancy		.366	

Helping in the house/fetching water/firewood	1.310	.056	3.708
Cooking	.889	.135	2.432
Washing	-.761	.564	.467
Take care of children	.592	.496	1.807
Sweeping	-.130	.908	.878
Played no special role	RC		1.000
Person(s) consulted on knowing about pregnancy		.229	
Parents	.896	.087	2.449
Others	-5.040	.891	.006
Husband	RC		1.000
Constant	-.075	.963	.927
-2 Log likelihood	177.891		
Model Chi-Square [df]	54.502[16]		
% Correct Predictions	88.6		
Hosmer and Lemshow Goodness of Fit Test [df]	11.153[8]		
Number of Cases	289		

RC=Reference category

As shown in Table 4, the decision on spacing categories "Husband's decision alone", "Wife's decision alone" and "Husband and Wife's decision" are significant at 0.05 level (95 percent confidence level). The model reveals that women whose husbands took decisions on spacing alone have an odds ratio of 0.047. Hence, they are less likely to have Types 2 and 3 outcomes compared with situations where other people apart from a couple took the decision. Similarly, women that took the decision on child spacing alone and couples that took the decisions together have odds ratio of 0.041 and 0.068 respectively. These imply a less likelihood of having Types 2 and 3 pregnancy-outcomes than when such decision was not taken by couples. The differences in the likelihood of having less of Types 2 and 3 pregnancy outcomes among the above categories with regard to birth spacing derive from the almost similar views of the people with regard to birth spacing.

Considering husbands' reactions to sole decisions by women on the latter's health particularly reproductive health, the model reveals that in situations where the husband did not approve of the decision taken, the likelihood of experiencing Types 2 and 3 pregnancy outcomes is reduced by almost half (with an odds ratio of 0.598) compared to situations where the husband just "understood". In situations where husbands were indifferent to decisions taken, the odds ratio is 22.73 thus, the women are more likely to have Types 2 and 3 outcomes when compared with situations where the husband

accepted such decisions. Lastly, in situations where the husband was not aware of his wife's sole decision, the likelihood of experiencing Types 2 and 3 pregnancy outcomes is higher (odds ratio of 11.194) when compared with women whose husbands accepted such decisions. The indication is that the disposition of men towards their wives' sole decisions regarding reproductive health, especially on activities associated with prenatal, delivery and postpartum periods, influences how much the former (men) would support the latter (women) during those maternal periods. Isiugo-Abanihe (2003) has demonstrated that male role and responsibility with regard to reproductive health is significant for maternal outcomes and should be strongly emphasized. This emphasis on the contributions of men at the above periods has stronger meaning in rural communities where attitudes and behaviours are still largely defined by patriarchy.

Women who consulted their parents on knowing that they were pregnant are more likely (with odds ratio of 2.449) to have Types 2 and 3 pregnancy outcomes compared to women that consulted their husbands, while women that consulted other people are significantly less likely (with odds ratio of 0.006) to experience similar pregnancy outcomes as compared to when they consulted their husbands. The message conveyed by the model in table 19 is that male dominance in household decisions including on reproductive health impinges strongly upon pregnancy outcomes. Hence, understanding power relations between couples within a social system is relevant in the analysis of women's health. Ottong (1993) has observed that some of the health hazards faced by women particularly in the course of childbirth, result from their deprivation, neglect and denial of rights in the society. On the contrary, the Ibani (both men and women) have inclination for patriarchy and approve of male leadership at both community and household levels.

Supporting such dominance are data elicited from group discussants of various categories. Hence, there is an overwhelming consensus on the imperativeness of the creation and recreation of patriarchy as a necessary mechanism for sustaining order in Ibani society. According to one male FGD participant in age category 25–29:

Right from when our great-grand fathers came to settle in Bonny, we have only had male kings (Amanyanabo) as the overall rulers of our people. Among our 14 major houses, only men are chiefs. In fact, it is inconceivable for women to attempt to succeed to any of these thrones. It is something that we grew up to see and acknowledge as desirable. That our People are gentle is explicable by the activities of men as rulers; our elders have on several occasions persuaded the youth against violence… women are too soft to handle certain important assignments. When we go to war, it is expected that the women should stay and look after our children…these women even know

it is a taboo for them to aspire to the Amanyanabo position… (Sinciminabo-Ofori. 18/06/02)[4].

The above statement on one hand re-echoes the Hobbessian problem of order in every known human society for which the need to cohere is a constant concern. On the other hand, it is an attempt at justification for the inequity that inheres in patriarchy. Gender inequality in this respect becomes a matter of conception, which in most African communities until very recently was imperceptible by women. Maintaining male dominance entails the infusion of false consciousness into the socialization process in order to blur any propensity for women to reappraise the socio-cultural environment vis-à-vis their inherent position in the society. This point is indicated in the view of a female FGD participant in the age group of 50+ years, who noted that:

Men are men, and there are duties, which only they can perform. No Ibani woman has ever been or will ever be the king. Indeed we consider it a taboo for women to even think along that line. The Amanyanabo throne is divinely determined and the gods do not allow women to undertake such task that is ascribed high ritualistic significance. In the olden days, women were not allowed to engage in most cultural activities but depended wholly on their husbands for both information and instructions. Presently, they are partaking in some of these traditions (Dublin Green. 17/06/02)[5].

Most Ibani women share the above view. The implication is that they have unwittingly accepted the supposedly inviolable definition of the socio-cultural context and the activities that sustain such power structure by their male counterparts. These women are socialized to perceive the situation as normal to the extent that supernatural connotations are further employed to heighten the acclaimed inevitability of patriarchy. Over dependence on men on matters that directly affect women and for which the latter have privileged knowledge can have devastating effect on them and their entire families. Must a woman wait for her husband to come home to instruct on her medical requirement before she could seek care? If she does without his consent, even when he is "out of sight", does it affect their relationship/communication? Although Ibani men have strong control over the activities of women, should they not have confidence in the ability of their wives to effectively take reproductive health decisions at emergency situations? Allowing women to express as well as realize their inherent potentials suggest warm family relations and not only ensures that prenatal activities are positively undertaken but also that safe-motherhood is achieved.

[4] Sinciminabo-Ofori

[5] Dublin Green – for ethical reasons, these pseudonyms are used to represent FGD participants.

The complementary role of men in the pregnancy-postpartum processes beginning from family planning is a prerequisite to achieving Type-1 pregnancy outcome. However, socio-cultural environments dictate how much women are involved in family decisions and by implication in influencing the processes. Among the Ibani of Rivers State, the influence of patriarchy on the activities of individuals generally still shows a strong emphasis on male-dominant system of relationship.

Conclusion

This study examined maternal crises in Africa, which given its male dominant status have links with activities of men in relevant societies. Investigations have shown that although men dominate most family discourse, including reproductive health, they do not undertake the level of responsibility necessary for successful pregnancy outcomes. Where inadequacies such as poverty, illiteracy, poor medical facilities and low status of women that impinge negatively on maternal conditions are quite evident, as in Africa, more sensitivity and support are required from men than in places where these socio-economic problems are minimal.

Enhancing the role of men during maternal processes is a critical factor in ensuring that pregnancies are less vulnerable to mishaps. Consequently, educating men on the need for family planning, child spacing and moderate family size will improve pregnancy outcomes significantly. This is especially true where a wife's fertility preferences and behaviour are largely influenced by her husband's reproductive intentions. The attitudinal change, among men, proposed by the present paper will contribute to reducing maternal crises among the Ibani of Rivers State, Nigeria and most other societies in Africa.

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