EMERGENCY OBSTETRIC CONDITIONS, HEALTH SEEKING BEHAVIOR AND SPOUSAL ROLE IN SOUTHWEST NIGERIA: MOTHERS' PERSPECTIVES.

By

Clifford O. Odimegwu, PhD
Takemi Fellow, 2001-2002
Harvard School of Public Health
Boston, MA 02115

Second Research Report submitted to

Program Coordinator
Takemi Porgram in International Health
Dept of Population and International Health
Harvard School of Public Health
Boston, MA.

JUNE 2002

\

Abstract

This article examines women's perspectives of their spouses' role in emergency obstetric conditions and care in the Southwest region of Nigeria. Data for this study come from a 1998-1999 community-based survey on men's role in emergency obstetric care in Osun State, Nigeria which includes information of individual characteristics, awareness, perception and experience of emergency obstetric conditions. The data collection was done using questionnaire, focus group discussions and in-depth interviews. The current analysis is based on women-based data set. While some simple statistics are provided for the occurrence of some of the key variables, our analysis is mainly based on the qualitative data, as we wanted to 'hear from the women what their spouses are doing in their pregnancy situations'.

The findings suggest that though men are major family decision-makers, women can also exercise such decision ability especially when it comes to emergency obstetric conditions. There is an improved awareness of the seriousness of some of the emergency obstetric conditions, as most women do not see some of the signs as normal. For instance, swelling of the feet is seen as a very serious matter as against former position whereby women see this as a sign of the birth of a male child. Women often complain of marginalization and this finding has shown that there is a process of social change in this part of Nigeria. The women have spoken*:"we need the cooperation of our husbands in all our situations"*, though they have been helping in emergency conditions. Sources of this societal change are identified in this paper.

Introduction:

Out of the estimated 27 million women of reproductive age in Nigeria, one in thirteen die due to causes related pregnancy. Recent figures indicate that the maternal mortality ratio in Nigeria is one of the highest in the world despite decades of activities associated with the Safe Motherhood Initiatives (WHO, 2001:11). Current estimate for Nigeria show that the rate is between 1000 and 1500 per 100,000 (UNFPA, 2001:25, Odimegwu, et al 2002:20, Adewuyi et al 1999:5). Maternal mortality rates are twice as high in rural settings as they are in urban ones. Of the annual 3 million pregnancies in Nigeria, approximately 170,000 result in death that is mainly due to complications during pregnancy and childbirth. The main causes of maternal mortality in Nigeria are due to complications such as hemorrhage which account for about a quarter of all maternal deaths, sepsis (15%), complications of, unsafe abortion (13%), hypertensive disorders of pregnancy (12%) and obstructed labour (8%). (WHO, 2001). For instance, it is reported that in a certain study in Nigeria, of the maternal deaths reported, 22.4 percent were due to abortion complications. The level of maternal death in Nigeria indicate that women experiencing seven pregnancies during their reproductive spans will have one chance in 25 of being a victim of maternal mortality (Asowa-Omorodion, 1997:1817)

One of the outcomes of the Safe Motherhood Initiative was the development of a number of research initiatives to address the problem of safe motherhood. One of these is the Prevention of Maternal Mortality Network. This Network, made up of expert gynecologists, obstetricians and social scientists, identified set of factors associated with maternal mortality. For instance they observed that most communities regard pregnancy and delivery as natural processes; signs and symptoms are not always recognized as

reasons for concern; etiology of complication, women's status and family system affect use of health care services.. Other factors were identified by the network (PMMN, 1992:279). Maine et al (1987:5), Royston and Armstrong (1989:11) also organized the causes and risk of maternal mortality under such categories as obstetric, health service, reproductive, socioeconomic and transportation factors. Other authors have examined the entire process that culminates in maternal death or serious maternal morbidity. Among these was Fathala who coined the phrase the 'road to death' which women follow and this road starts with the underlying socioeconomic conditions of life and continues to include the demographic and health service factors that contribute to death (Fathala, 1987:8). Thaddeus and Maine (1990:5) examined the event of pregnancy complication and the various factors affecting delays in deciding to seek for medical care, in reaching a place where care is available and in receiving appropriate care. These are what they called 'the three delays'.

Giving reasons for these delay, the Prevention of Maternal Mortality Network (1992:12) identified women's inability to recognize signs and symptoms of complications, attitudes and values, and women's status and the culture of husband's permission or male dominance ideology. They reported that in some parts of Nigeria, swelling of feet during pregnancy, a sign of eclampsia is seen as an indication that the baby will be a boy or and twins as in Ghana. Small amount of bleeding – an early sign of antepartum hemorrhage, is not considered a cause of concern. Thus when a complaint occurs, the decision of where to seek for care depends on what is thought to be the cause of the complication. Hence access to health care in emergency obstetric conditions is reported to be dependent on women's status within the society and the family. The

husband's permission is required before a woman seeks for treatment Harrison (1997:5) and Adewuyi (1999:5) reported that in some parts of Nigeria, spousal permission is important before a woman in emergency obstetric conditions attends to health care. In the absence of the male head of the household, any male member present must accompany her to the clinic. In most cases it is reported that these women wait for their spouses. Similar studies in Senegal found also that women cannot and do not decide on their own to seek care; the decision belongs to the spouse or senior family members. In Senegal, 52 percent of the respondents said the husband would make the decision and 44 percent said another family member would make the decision (Dia et al 1989:10).

Also at other times especially when the couple could not provide money for the hospital care, the decision about where to seek care is made by the community leaders who can override the husbands wishes. Furthermore a woman who has children and does not have the ready support of her extended family has problems finding people to care for her children (Center for Health Research, 1991:50; PMMN, 1992:278, 1995:657). This has led to the conclusion that in Nigeria, women do not seek for medical care even under emergency obstetric conditions until they get permission of their spouses. It is also reported that men do not play any role in the pregnancy experiences of their partners while they are accused of demonstrating patriarchal dominance in the health concerns of their partners especially in obstetric conditions. (Adewuyi 1999:6).

One major flaw with these studies is the inability to contextualise a male partners behavior and role in emergency obstetric conditions. Thus we do not have a clearer view of the extent men partake in the pregnancy care of their spouses. Hence this study is intended to re-examine the evidence of male role in emergency obstetric care in Nigeria

with the most current community-based data collected from the Southwest region of Nigeria. We are looking at this issue from the perspective of the women themselves. The basic question is what is the role of your husband in your obstetric conditions? Is your spouse involved in your pregnancy care and management? There is need for program planners to include clients perspectives in their program design.

Methodology

This study was done in the Osun State, in the Southwestern part of Nigeria. Three communities were randomly selected in the State and these were Ode-Omu, Otan Ayegbaju and Ejigbo. In each of the towns, 300 households were selected. With no sampling frame, we conducted a household listing in each of the towns from which a minimum sample of 300 households was selected. In each household, different interviewers who have earlier been trained for the field exercise interviewed a man and his wife, separately

In some households, it was expected that husbands would have more than one wife. In such a case, we interviewed all the wives in any polygynous setting along with their husband, provided the wives are still within reproductive age group. In this case, we noted the hierarchy of wives by date and age at marriage to the current husband. However, we did not get much usable information from most of the women.
At the end of data processing, we interviewed a sample of 1,200 women of reproductive age group 15-49.

Our data for this analysis drew heavily from the qualitative aspect of the study. In this case focus group discussions were held with eighteen groups of women. Thus we had

six in each site. Each focus group had participants with the same qualities. For example, one group consisted of married women between age 15 and 25. We categorized the focus groups into young women (aged 15-25), middle-aged women (aged 26-35 years) and older mothers (aged 36-49). Once the qualities required of the participants were defined, we ensured that the various household settings or compounds in the sites were represented.

Each focus group discussion session lasted around two hours. The sessions were coordinated, moderated and directed by the two sociologists in the research team. Yoruba, the indigenous language of the area, was used in the sessions. This allowed for a deep exploration of the women's real experiences and feelings. Each session was recorded and then transcribed to English by an expert transcriber. Verbatim transcription of recorded tapes maintained the originality of the discussions (Asowa-Omorodion, 1997:1817).

While we highlighted some of the quantitative findings, we based our interpretation and discussion on the excerpts from the focus group discussions and in-depth interviews.

Findings

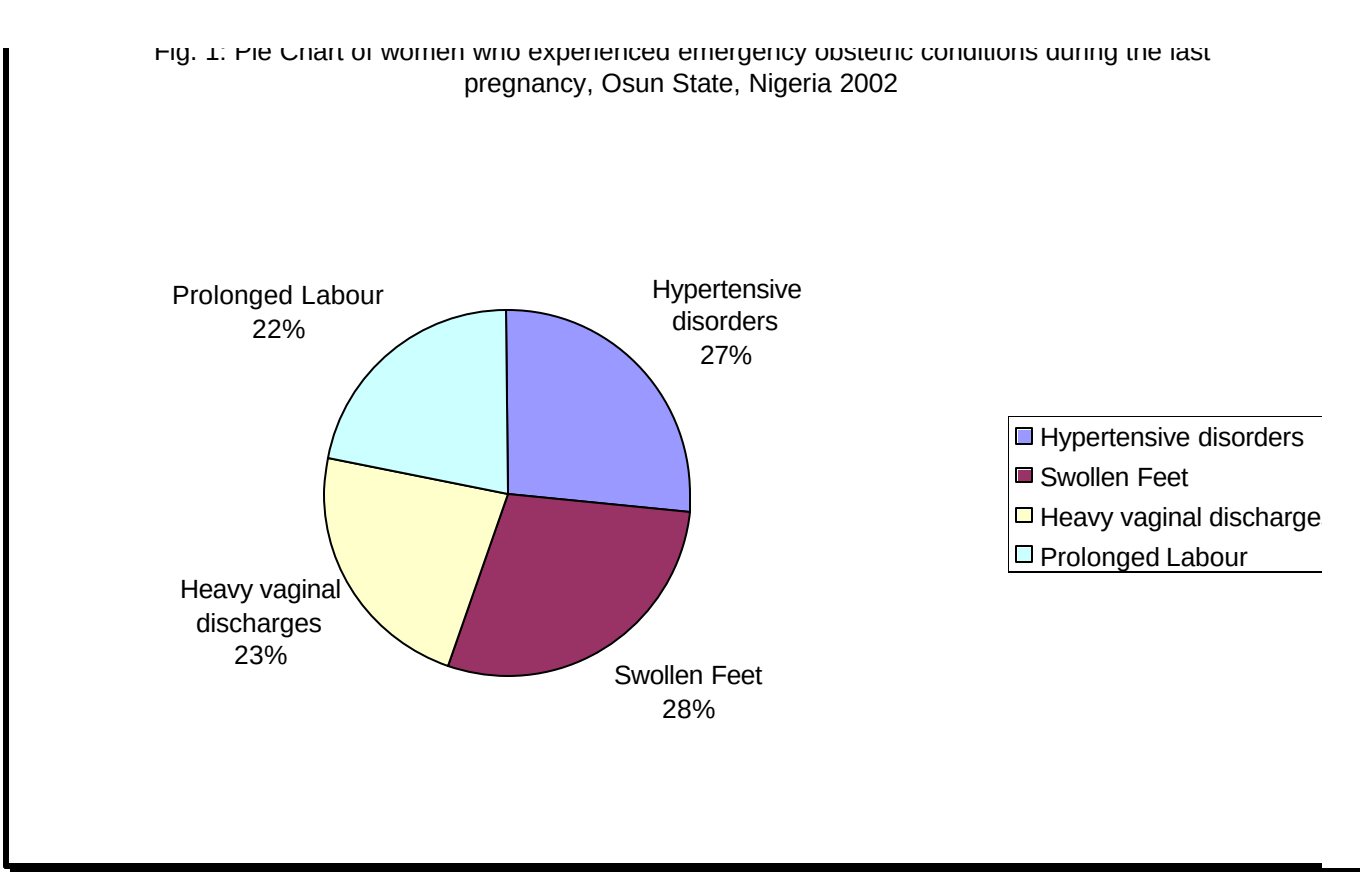
Respondents' Profile.

The mean age of the participants was 28 years and majority of them attended different levels of education. One-quarter did not go to school, 17 percent attended primary school and one-third did secondary education. Slightly a little above one-quarter did tertiary education. On the average, each of the women was married for eight years

with an average of three births per woman. About 36 percent had current pregnancy as at the time of the sessions.

The average number of children ever born by these women is about 8. There is a high level of wantedness of pregnancy as last pregnancy was wanted by 82 percent and 13.4 percent wanted later but 'it just happened' and 4 percent wanted no more but 'it happened all the same'. Almost all the women visited the antenatal clinic during the last pregnancy and antenatal care attendants are nurses and midwife (73%). Pregnant women visit health center (48%) and private hospitals (38%). Few reported attending to the teaching hospitals, which is the highest level of health care in Nigeria. More than half of the women sought for treatment when they were sick during their last pregnancy. More than two-thirds said their spouses recommended or chose the place for treatment during their sick period and were accompanied either by spouses or co wives to the health center.

Fig. 1: Pie Chart of women who experienced emergency obstetric conditions during the last pregnancy, Osun State, Nigeria 2002



EXPERIENCE OF EMERGENCY OBSTETRIC CONDITIONS

Fig. 2: Pie chart of other obstetric conditions experienced, Osun State, Nigeria 2002

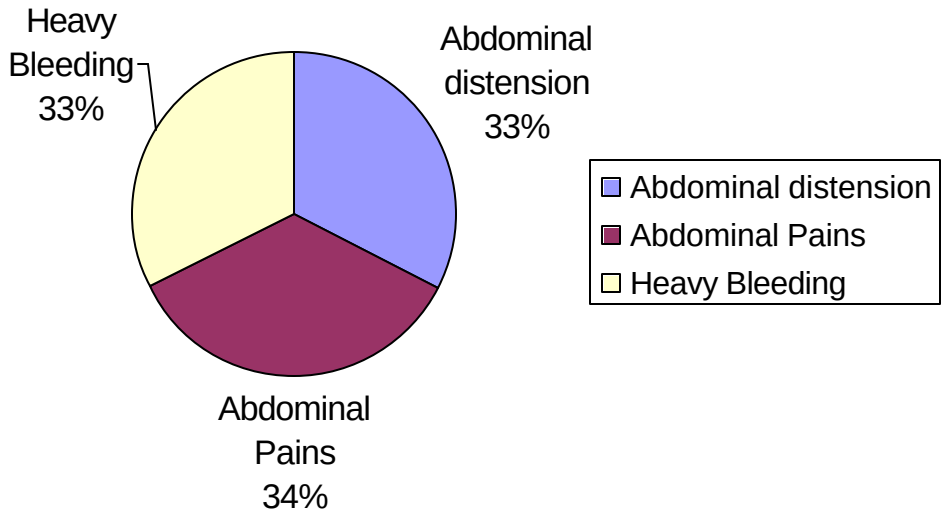
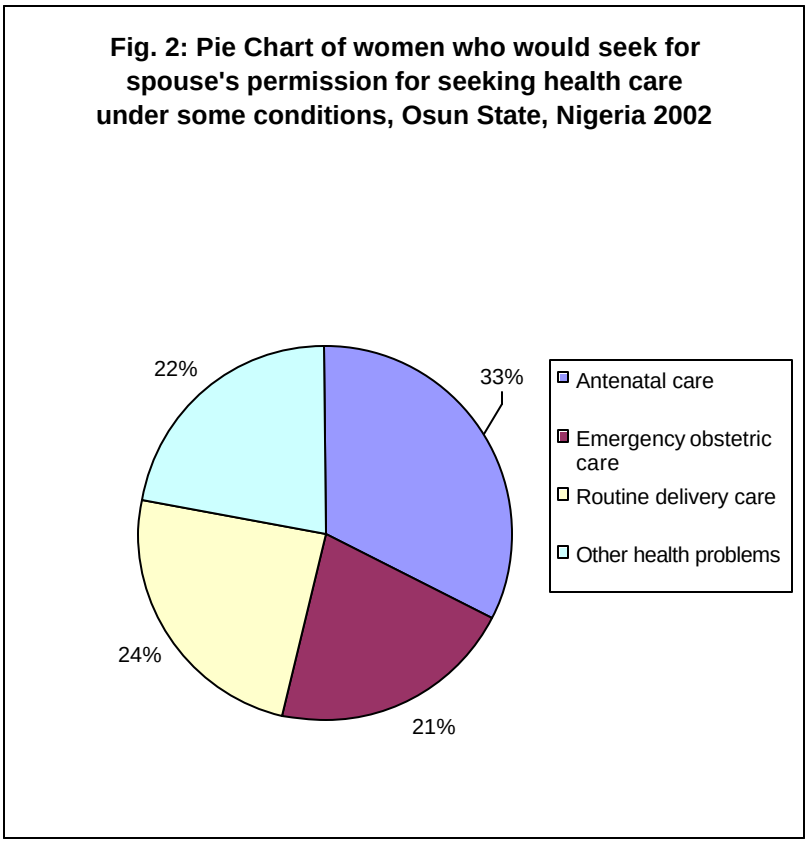
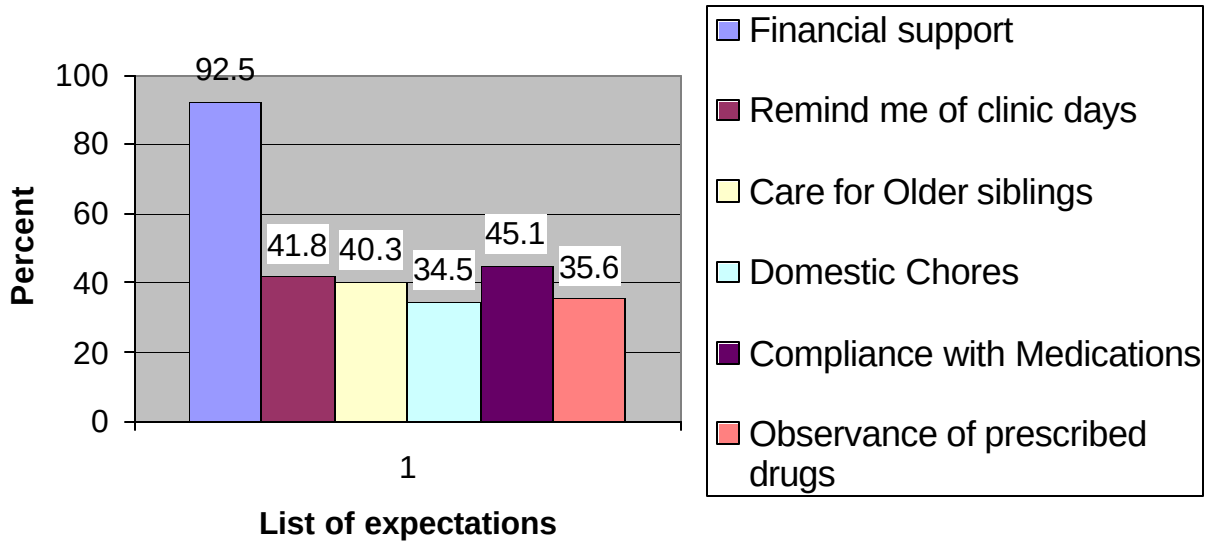


Fig. 1 shows that while 28 percent experienced swollen feet during last pregnancy, 27 percent had hypertensive disorders. Also more than one-third experienced abdominal pains, heavy bleeding and abdominal distension

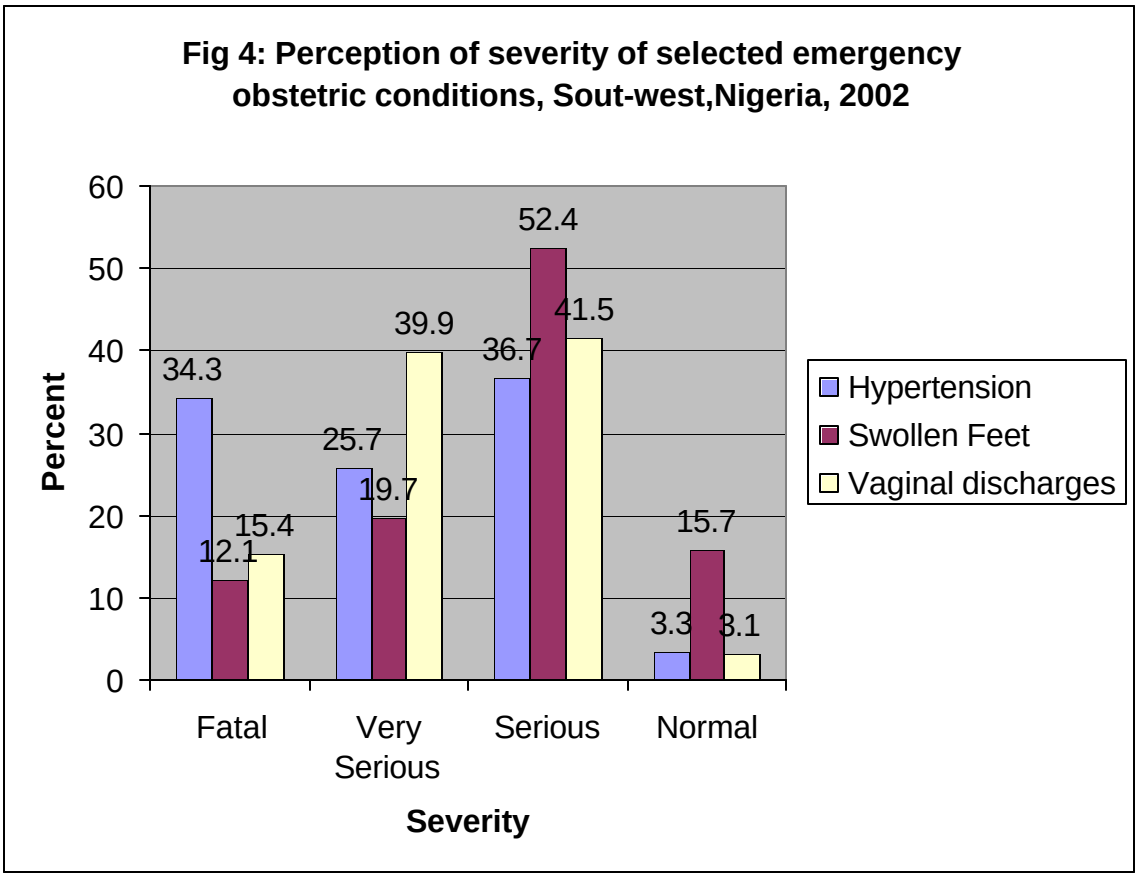


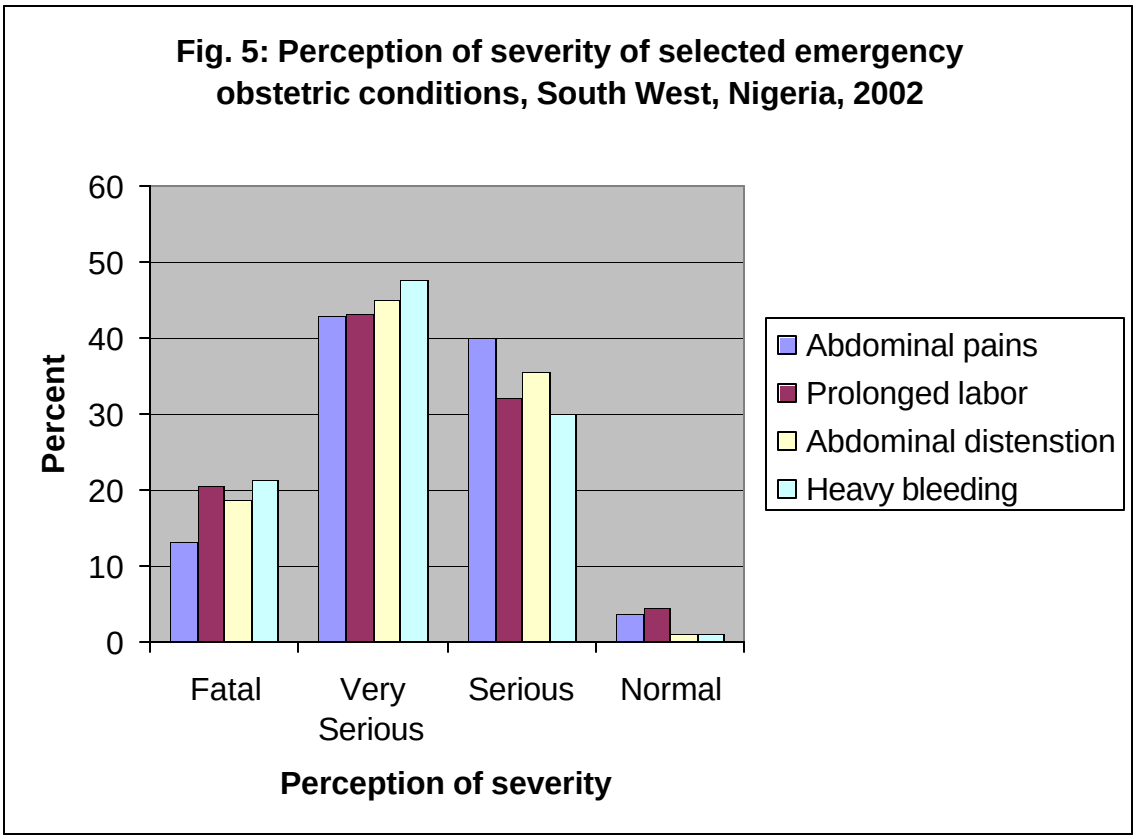
One-third of the women would seek for their spouses permission for before they go antenatal care clinic, one-fifth would do same in emergency obstetric conditions, routine delivery and other health problems. During pregnancy, most of the women expect their spouses to provide the finance for medical costs – a situation which we found to explain the reason why permission is sought from the husband.; compliance with medications , reminding the wife of clinic days, caring for older children and doing domestic chores and helping the women to observe prescribed resting periods. (Fig. 2).

Fig. 3: Women's expectations from spouses during pregnancy, SouthWest, Nigeria



Perception of Emergency Obstetric conditions.





All the selected emergency obstetric conditions are seen as mainly 'serious' and 'very serious'. Those perceiving them as normal are less than 5 except in the case of swollen feet where 16 percent of the women said that it is a normal sign in pregnancy

Decision-making

The spouse makes family decisions on some obstetric matters. For instance, more than half of the respondents claimed that their spouses decided when they would have their last pregnancy followed by one-third who said the decision is a joint one. This supports the common finding that the decision about the next child in Nigeria is that of the men (Omideyi et al 1999), although one shortcoming of these studies is their inability to investigate other underlying reasons why men determine the next-child project. The

spouses also are claimed to be the decision-makers for the place to go for delivery while about eight of every ten respondents claimed that they normally inform their partners on their decisions about antenatal care. Reasons for this pattern of response will be better understood in the section dealing with the qualitative data. However one problem with the study is the inability of the women to separate 'informing their spouses' from 'obtaining permission'.

However when asked about the decision a pregnant woman would take in the absence of the spouse since it is claimed that he is the main family decision-maker, 81 percent of the respondents in the event of emergency obstetric conditions in the absence of their partners, said that they would take decision alone without consulting anybody or waiting for their partners.

Examination of the above pattern of responses by age and education does not show any significant differences. In the case of age, both the young and old have the same pattern of responses. Ditto for the level of education. For instance, about 97 percent of the respondents attend antenatal clinic irrespective of the age and educational level. This again shows the fact that there is a significant understanding of health implications of emergency obstetric conditions. (Table not shown).

Perception of Men's roles in Wives Health Status: Qualitative analysis.

The women in the various focus group discussions and in-depth interviews perceived some roles as ideal for the husbands in maintaining the overall health of their spouses. These women across the various social strata noted that an ideal husband or partner should be able to 'provide food, clothing and shelter for his wife". Other

identified ‘ financial assistance’, ‘provision of money’, ‘taking wife to the hospital for treatment to ensure her health” as the ideal roles of a husband. The men were claimed to be assisting in buying recommended drugs from the pharmacy during the wife pregnancy also.

Actual positive roles played by men in obstetric conditions.

We asked the women to discuss actual roles their spouses played in their obstetric conditions. This was to find out if the perceived roles were actually performed by the men. Majority of the participants reported that their spouses provided ‘orthodox health care by taking them to the hospital when they were sick”, ‘took adequate care of me”, and ‘rendered assistance in domestic chores, either helping to take care of my older children, preparing them to school, cooking food for them or overseeing their activities etc”.

Some other husbands also helped their pregnant wives to comply with medication regulations and observed prescribed rest periods. However it was pointed out that the educated men tend to take care of their wives more than the uneducated ones. This could be so because apart from being socially aware of the importance of good health for the family, beginning with the wife, the educated husbands are more likely to be gainfully employed and have higher incomes. They are more socially and economically exposed than otherwise. This point was well emphasized in twelve of the focus group sessions.

Negative roles of the husbands.

Apart from the actual roles performed, the women noted that some men or male spouses do not live up to the expectation. Some of the men never took part in ‘domestic chores’. There is ‘wife neglect’, ‘some men do not pay hospital bills’. Other show

outright indifference to the pregnancy. However our impression is that this is more of a poverty-associated problem than a cultural phenomenon of unwillingness to pay. As a result,

> *"Some of us finance our pregnancy because we do not want to die in pregnancy. If we die, our children will not be properly trained. Our spouses will take other wives."*

A female opinion leader observed that

> *"Men in this community see their wives as filthy rags. Their only hope and joy with them is sexual intercourse. Once the wives are pregnant, they desert them and will be running for other women, till that time when they will be free for sex again. They do not care for the pregnant women. It is not all men that can be accused of this."*

Women, aged less than 35 years in the eight sessions of our focus group discussions, reported that,

> *"The first reasonable thing a caring husband does is to take his wife to the hospital or maternity or clinic for registration for scheduled clinical visits as soon as pregnancy occurs. He must monitor the regular visits of his wife to the hospital, making sure she attends antenatal clinic whenever due till delivery time. Whenever she comes back, the husband must enquire of what the medical staff said about the health of the woman and the pregnancy. He must also provide money whenever she is going to the clinic. But if he does not have, he has to explain to his wife so that she will understand the circumstances …but some men do not do this …"*

A woman aged 35 years old agreed that

> *'My husband now ensures that I use all the prescribed drugs."*

However, another commented on her spouse's negative role thus:

> *"Many husbands leave home in the morning, only to return in the night. Can such a man ever know or care for a wife during pregnancy or emergency". – (FGD, women > 35 years).*

This is often the case with women whose spouses are involved in long distance business like truck driving, trading and artisans who can travel long distance to do a job.

Men's awareness of obstetric conditions

It was generally agreed by the respondents that their spouses' knowledge of pregnancy, obstetric conditions and outcomes are not adequate enough. They believe these

> *"Men may not know much after all it is not their profession to examine a pregnant woman. Also our culture has an element of secrecy over pregnancy. You can tell a fellow woman what you are passing through because she will understand you than the man who in most cases know nothing about pregnancy".*

Also some of the men may know simply because of their level of education, social awareness, interaction and exposure to public health issues. Men whose wives have had more than one pregnancy may be in a better position to know much about obstetric conditions having been through the process of motherhood a number of times. Men's knowledge of pregnancy signs and symptoms of emergency obstetric conditions vary across socio-economic groups. No matter the level of knowledge claimed by men, it cannot be adequate as that of their wives or of those in the medical profession. Generally, the respondents agreed that what men know about pregnancy and associated problems is inadequate.

As men are becoming aware of the importance of adequate knowledge of pregnancy and its outcomes, more of the respondents indicated the need to "take proper care of wives", "to prevent problems in pregnancy", "to make adequate preparation for the baby" and to "monitor the state of the health of the women in pregnancy".

The participants believed that men are now concerned with pregnancy and pregnant outcomes because of the understanding that serious ill health could be prevented in

pregnancy if detected early, and with proper action. It is also to avoid costs that will arise from other consequences of neglected health treatment.

Contrary to the traditional view that husbands would normally take major decisions on pregnancy and emergency obstetric conditions, many women expressed the opinion that though their men can decide on most things, when it is a matter of their health and life chances, they would initiate action and take decisions to seek for health care. These women take decisions on when to visit health center and in emergency situations, neither do they wait for the spouses to take the decision. Most of the women reported that even when they had taken such decisions, their partners never bordered them or kicked against it. It is reported that the factors responsible for some husbands' non-involvement in pregnancy are poverty, drunkenness, carefree attitude, unemployment, illiteracy and ignorance. They suggested that in a bid to educate men about pregnancy matters, the content should include "time of conception", development of pregnancy, sign of pregnancy and physiological changes and underlying problems of poverty should be addressed.

Conclusion.

This paper examines women's perspectives on spousal role in emergency obstetric conditions and care in a sub-ethnic group in Nigeria. It shows a high level of awareness of obstetric conditions and an understanding that they are 'serious', 'very serious' or 'fatal' and hence would need emergency medical attention. Most of the women have a high level of awareness of emergency obstetric conditions and their

severity. There is also high attendance at antenatal clinic for pregnancy care. Most deliveries took place in health centers located in the rural communities.

Though there was a general agreement about the changing role of men in emergency obstetric care, most of the respondents reported that their men still decide on major family issues like next child project, place for antenatal care and delivery. This decision is explained within the context of the fact that men are traditional financiers of pregnancy and its attendant outcomes. Men pay for antenatal care and other related bills. When the women reported that their husbands make the decisions about antenatal, emergency care,

> *"It does not mean we do not take decisions. It means that we accord them the respect due to them as the heads of the household and as the one that will pay for the incurred bills. We can make decisions too. In the matter of pregnancy and all the associated risks it is true that some men do not understand the burden, but generally our husbands assist us during pregnancy. When I ask him for permission, I imply that he should give me financial support as I am going to the hospital…." Female opinion leader.*

Most men in this area of site assist their partners to seek for health care during emergency obstetric conditions. Most women in the various sessions noted that though their men decide on a lot of things that they (the women) still have right to decide on some other things. For instance, the women said they could decide where to go for health care in case of emergency. The men do not force them to follow their line of action. They argued that the decision of their husbands is borne out of kind consideration and not of intimidation. The decision of the men is governed by a lot of factors, among which is the financial state of the man at the point of the decision.

That the women take permission from their partners for any health care attention they need – antenatal, routine service, emergency care etc, is a result of the fact that men

are financially responsible to their partners. It is one of the aspects of marital responsibility that the man foots the bills of the family. Payment of antenatal clinic bill might not even be associated with the wife's ability to pay but as a traditional responsibility of the husband. No matter how rich a woman is, it is the responsibility of the husband to pay the antenatal care bills and all bills associated with the emergency obstetric conditions (Raimi et al 1999:71).

The women are concerned with the low level of awareness of pregnancy signs and symptoms and rightly called for educational programs to address this lapse. There is the need for intensified enlightenment and education campaigns in emergency obstetric conditions that require attention as well as against practices that could jeopardize successful pregnancy outcome. This intervention has to target men and women of low socio-economic status and in rural areas. As these cultural issues are being taken care of, other factors affecting access to emergency obstetric care should be attended to such as health facilities and infrastructure development, and other underlying social conditions like poverty. For despite the significant progress in eliminating cultural practices inimical to women's health, maternal mortality remains high. We should begin to look beyond cultural factors as this study has shown that there is progress in the area. Men are no longer much of the problem inhibiting the health of the women.

As efforts in this area continue, the statements of some of the women in the focus group discussions become relevant.

Participants in one of the groups commented thus:

> *"…. Pregnant women should not attempt to play with their wives. If they depend on men thinking of receiving help from them, they (the women) are playing with their life. If your husband is*

> *reluctant, there is no need waiting for him. Take action yourself for your own life …" (– FGD with women > 35 years).*

Another group opined,

> *"… Women should be emergency alert. Otherwise she may lose her life and the spouse will remarry " – FGD with 35+ years women*

They however added,

> *"We need the cooperation of husbands to attend the clinics*". This

is indispensable for a successful pregnancy outcome.

References

Adewuyi, A.A (1999): Pregnancy care: Understanding Male Involvement in Maternal Emergencies. CRERD, Nigeria

Asowa-Omorodion, F.I. (1997): "Women's perceptions of the complications of pregnancy and childbirth in two Esan Communities, Edo State, Nigeria", Social Science and Medicine, 44 (12): 1817-1824.

Center for Health Research, Consultation and Education, John Snow, MotherCare (1991): Qualitative research on knowledge, attitudes and practices related to women's reproductive health", Arlington, Virginia, JSI, MotherCare Project, 4, 54; 50p; Working Paper No. 9

Dia A. et al (1989): 'Maternal Mortality in Senegal' in Senegal: Contributing Factors in the health system and the community. Draft Report.

Fathala, Mahmoud (1987): "The long road to maternal death", People (14), 3:8-9.

Harrison, K.A (1997): "Maternal Mortality in Nigeria: The Real Issues", Commentary in African Journal of Reproductive Health, 1-6.

Maine, Deborah et al (1987): "Prevention of maternal deaths in developing countries: Program Options and practical considerations", paper presented for the International Safe Motherhood Conference, Nairobi, 10-13 February.

Obermeyer, C.M. (1993): "Culture, Maternal Health care and women's status: a comparison of Morocco and Tunisia", Studies in Family Planning, 24 (6): 354-365.

Odebiyi, A.O., Bisi Aina, F. Adesina and M.O. Raimi (1999): "Societal attitudes and perceptions of men's roles in emergency obstetric care", in A.A. Adewuyi (ed): Pregnancy care: Understanding Male Involvement in Maternal Emergencies. CRERD, Nigeria. P. 18-34.

Odimegwu, C.O et al (2002): 'Men's role in emergency obstetric conditions and care in Nigeria', Submitted to International Family Planning Perspectives, New York

Omideyi, A.K , M.O Raimi and C.O. Odimegwu (1999): "Couples reproductive decision-making in Nigeria", Research Report Submitted to Population Research Fund/Nigeria Social and Economic Research Center (NISER), Ibadan, Nigeria.

Preventing Maternal Mortality Network (1992): 'Barriers to treatment of obstetric emergencies in rural communities of West Africa', Studies in Family Planning, Sept-Oct, 23 (5): 279-291.

Preventing Maternal Mortality Network (1995): 'Situation Analysis of emergency obstetric care: examples from eleven operations research in West Africa', Social Science and Medicine, 40 (5): 657-667.

Raimi, M.O, A.B. Adeyemi and A. Odebiyi (1999): 'Health-seeking behavior in pregnancy and implicatiosn for emergency obstetric care' in A.A. Adewuyi (ed): Pregnancy care: Understanding Male Involvement in Maternal Emergencies. CRERD, Nigeria. P. 71-86.

Royston, Erica and S. Armstrong (eds) (1989): Preventing Maternal Deaths. Geneva: WHO.

Stock, R. (1983): "Distance and the utilization of health facilities in rural Nigeria', Social Science and Medicine, 17 (9): 563-570.

Thaddeus, Serene and Deborah Maine (1990): Too far to walk: Maternal Mortality in Context. New York: Columbia University, Center for Population and Family Health.

UNFPA (2001): State of the World Population, 2001.

WHO, UNFPA, UNICEF and World Bank (2001): 'Saving mothers' lives', Joint Agency Statement on reducing Maternal Mortality. Entre Nous, 2001 Winter-Spring 49:11.

WHO (2001): Country Program Report, Nigeria, Making Pregnancy Safer, www.who.int/reproductive.health/mps/Nigeria_country_report.html.

ACKNOWLEDGEMENT

I am grateful to John D. and Catherine T. MacArthur Foundation, Chicago, USA for sponsoring the survey under Grant Number 41863. The role of the entire staff of the Center for Research, Evaluation Resources and Development, Ede, Nigeria in the implementation of the project is deeply appreciated and to the Management of Takemi Program in International Health for logistic support to do the analysis. I am grateful to everyone who contributed to the successful implementation of the project and to my stay at Harvard especially Phyllis Kanki, the director of AIDS Prevention Initiatives in Nigeria, for the financial support.