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WOMEN'S PERCEPTION OF MALES' INVOLVEMENT IN MATERNAL HEALTHCARE IN RIVERS STATE, NIGERIA

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ABSTRACT: *Men play a significant role in the reproductive life of women, from the pre-pregnancy stages of family planning to pregnancy, birth and post-natal periods. This study was a survey of the perceptions of women on males' involvement in maternal healthcare in Rivers State. This involved some selected health centres in Rivers State, using a pre-tested and validated questionnaire. Aspects of men's involvement that were taken into consideration included decision-making, economic and geographic accessibility as well as utilization of maternal health-care services. Responses from a total of 300 pregnant and post–natal mothers who were purposively selected from randomly drawn health centres in the three Senatorial Districts in Rivers State were analyzed. The results showed no significant difference in the perceptions of women with primary or post-primary education, unemployed or employed women as well as those residing in rural or urban areas. In addition, there was a unanimous agreement that joint decision-making was better than a decision solely taken by the man or woman alone. They all agreed that financial empowerment and autonomy were crucial for enabling women to access and utilize maternal healthcare facilities. It was concluded that despite the pivotal role of men in family affairs, their involvement in maternal health process was abysmal and this could be due to some extraneous factors. The study therefore recommended that women empowerment, in terms of education and finances would go a long way towards improving maternal health which, over the years, has been on the decline, despite men's good intentions.*

KEYWORDS: Gender, Healthcare, Women, Men, Education, Nigeria

INTRODUCTION

The reproductive period in the life of a women is a critical period and spans several stages from the pre-pregnancy stages of family planning, pregnancy, childbirth and post natal period. It is rightly called critical because though the outcome is a positive expectation, many times it ends in debilitation or death. Maternal and infant mortality rates are social indicators used to measure the development of a nation, and the picture in Nigeria appears to be a gloomy one. Maternal mortality relates to death occurring in pregnancy and 42 days after delivery, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (WHO, 2007). It is likely that certain social, cultural and religious factors have contributed to poor maternal situation in Nigeria. This paper is hinged on the feminist theory of patriarchy identified as one of the causes of lack of male's involvement in maternal healthcare and by extension maternal mortality.

Patriarchy, in time past, was used to mean the power the father wields as the head of the home. It is now used to refer to an organized system of female suppression and domination (Kramarae, 1992). The relationship between the feminist theory of patriarchy and reproductive health has

been established as one of the dominant spheres of oppression. Reproductive health implies that people should have the ability to reproduce; women can go through pregnancy and child birth safely and that reproduction is carried to a successful outcome. By extension, reproductive rights entails being able to regulate fertility, ensuring safe sex to prevent sexually transmitted diseases and being able to go through the maternal process with favourable outcomes. This remains a farce in Nigeria because the country's patriarchal nature expects the man to be adventurous and risky without any recourse to his actions, while the woman bears the brunt of the consequences such as sexually transmitted infections like HIV/AIDS, reason being that she is no position to discuss or negotiate condom use or family planning methods.

Maternal Health Care in Rivers State, Nigeria

The traditional African culture has had an impact on women and their health. Women suffer various injustices due to the patriarchal set up in these climes. It is not just what is done to women, but what is not done for them. Maternal health is defined as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity in all matters relating to women of reproductive age (WHO, 2007). In addition, the researchers would like to add that maternal health situated in the African concept would mean the state of being able to exercise reproductive rights of family planning and access to basic focused antenatal care, without the encumbrances of patriarchy, financial or geographical inhibitions impacting on her overall health.

Maternal health care services comprise of a wide range of health services given to the mother before pregnancy, during pregnancy, labour and after delivery. It may also include services to prevent Mother-to-Child transmission of HIV (PMTCT) emergency obstetric care/management of obstetric complications. However, for this study, maternal health services refer to antenatal care, delivery and postnatal care.

In Rivers State, certain cultures and practices continue to impinge on maternal health, and by extension, the children. Nwokocha (2008) notes that among the *Ibani* people of Rivers State, women are prohibited from coming out during the popular and revered *Nwaotam* masquerade festival. Any failure to comply by any woman results in beating her up, no matter her condition, whether she is pregnant or not. Some cultures abhor women from eating eggs or snails, all of which are vital for their nutrition and that of their babies during pregnancy, leading to high incidence of iron-deficiency or anaemia that consequently leads to death, if not managed properly. Women are engaged in multiple roles of reproduction, home management and community building, to mention a few. They are defined by their reproductive roles, in addition to the very many household chores of fending for and tending the home front. Pregnancy is seen as normal physiological state. However, this is a time that women require improved nutrition, rest, focused ante-natal care as well as moral and financial support. This is not the case of many women found in Nigeria, hence maternal mortality has become a public health issue as statistics show that literally every minute, a woman dies from preventable complications of pregnancy, bringing the maternal mortality rate for Nigeria to 3200 per 100 000 live births (NDHS, 2008). NDHS states that these figures are worse in the Northern part of the Nigeria, heightening the worry that a process, such as pregnancy, can also be a life-threatening process.

Maternal health could be improved by family planning to promote child-spacing and ample time for the woman to recoup for the next pregnancy. Professional care during pregnancy is important in reducing the deaths from pregnancy-related causes. Different tiers of healthcare workers including midwives, nurses and doctors are crucial in providing antenatal care to follow up

pregnant women and act on any warning signs noted during pregnancy. The timely access to and affordability of specialist obstetric care during pregnancy is a major hurdle women are yet to scale through in improving their maternal health. Mitigating delays in taking a decision to seek specialist care, getting to a specialist centre and being able to afford access to this care will go a long way in preventing maternal mortality.

Males' Involvement in Maternal Healthcare

The involvement of men in maternal health is a new concept being adopted by the International community at the conference on Population and Development (ICPD) in Cairo, 1994, after tracing the remote causes of maternal mortality to cultural factors, chief of which is patriarchy. Highlights at the conference included the critical role of men as partners and change agents in improving maternal health and promoting healthy reproductive lifestyle among men. The ICPD devoted an entire section of its Programme of Action to male-involvement and responsibility. It called on men and women to partner in making healthy reproductive choices/decisions and be responsible for them. As UNFPA (1996:117) notes, this is to be achieved through:

The promotion and encouragement, by Governments, of the equal participation of women and men in all areas of family and household responsibilities, including family planning, child-rearing and housework. The emphasis of men's shared responsibility and the promotion of their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes. Ensuring that children receive appropriate financial support from their parents by, among other measures, enforcing child- support laws.

The pivotal role of men is depicted in their decision-making power as husbands, fathers and leaders in political and religious spheres. They are able to influence the reproductive life of their wives by determining, if they can use available family planning methods. Men control household decisions, their wives' ability to earn and control resources and the education of women and other members of the household (Nkungula, 2007).

The participation of men as change agents in reproductive health has a snowball effect in other areas such as abolition of harmful cultural practices like female genital mutilation, gender-based violence and the promotion of education and empowerment of the girl-child (Kinanee, 2005). It is not hard to imagine the positive impact that will be recorded, when men drive such burning issues, using their power to reverse harmful trends and promoting healthy reproductive practices and empowering their women. Discussing sensitive issues such as sexually transmitted disease with the care-giver in the presence of men sometimes leads to physical violence at home (Davis, Luchters & Holmes, 2013).

Women's Perception of Males' Involvement in Maternal Healthcare

In calling men to partner in the maternal healthcare process, it is wise to remember that women comprise the major stakeholders of the process. Women often express their desire to have their husbands accompany them to the clinics, sometimes to be educated about pregnancy processes,

related danger signs and corresponding solutions. They view this gesture highly as this promotes quality communication among couples and better joint decision-making. Women's expectations of their partners during pregnancy also include financially providing for them in terms of access and utilization of healthcare facilities. During labour, some women appreciate their spouses to be around to help rub their backs, hold their hands, pray with them or just to witness what women's experiences during child-delivery. In the post-natal period, support in doing household chores for women's relief in getting the needed rest and nutrition, while nursing, is of utmost importance to women (Ampim, 2013). Women's perception of their spouses' involvement in the reproductive process is a conundrum of different things and not all areas.

A gender approach is adopted in addressing this topic because of various social determinants of health and disease. Gender is related to reproductive health because of the following:

- It identifies the need for decision-making to be a joint venture between the man and the woman.
- It puts the values and experiences of women and men as unique but on the same scale.
- It highlights the critical differences in health needs and problems as unique for men and women which may have different implications.
- It leads to a clearer understanding of the causes of ill-health.
- It results in more effective solutions to health problems and
- It contributes to the attainment of greater equity in health and health care.

Statement of the Problem

Majority of maternal mortalities are largely preventable. There is however the misconception that these deaths are due to physical obstacles that prevent women from accessing maternal health services and on time. This study assumed that the root cause of delays and inability to access health services is the gender inequality that exists at home in terms of power imbalance in decision-making and financial strength tilted to favour the men. Culture and tradition socialize men and women into roles and leave the biological role of child-birth solely to women, without the needed social support of their husbands and partners they have not fared too well as statistics have shown so far. Studies show that socialization into sexuality and gender roles begin early in the family and community and are reinforced through the interplay of familial, social, economic and cultural forces, which are subsumed in patriarchy (Harrison, 1997). This gives rise to an increased desire among women for greater participation of men in maternal health-care. Women would like men to be more involved and have an interest in knowing more about pregnancy and child-birth, in order to meaningfully support them during this seemingly life threatening process.

Purpose of the Study

The study aims at investigating women's perception of males' involvement in maternal healthcare in Rivers State. The specific objectives are to:

1. Investigate the perceptions of educated women on males' involvement in decision-making in Maternal Healthcare in Rivers State.
2. Identify rural and urban women's perceptions of men in determining geographic accessibility to Maternal Health Service in Rivers State.
3. Investigate employed and unemployed women's perceptions of men in determining economic accessibility to Maternal Health Services in Rivers State.

4. determine women's perceptions on males' involvement in the utilization of maternal health services in Rivers State.

Research Questions

Emanating from the problems stated above are the following research questions:

1. What are the perceptions of educated women on males' involvement in decision-making in maternal healthcare?
2. What are the perceptions of rural and urban women on men in determining geographic accessibility to maternal health services?
3. What are the perceptions of employed and unemployed women on men in determining economic accessibility to maternal health services?
4. What do women think of males' involvement in the utilization of maternal health services?

Hypotheses

1. There is no significant difference between the perceptions of women with primary educational qualification and women with post primary educational qualification on the men's involvement in decision-making in maternal healthcare.
2. There is no significant difference between the perceptions of rural and urban women, with regard to men's determination of geographic accessibility to maternal health care.
3. There is no significant difference between the perceptions of unemployed and employed women in men's determination of economic accessibility to maternal healthcare.
4. There is no significant difference between in the perceptions of women whose spouse have primary education and those whose spouses have post primary education on males' involvement in the utilization of maternal health services.

METHODOLOGY

The study was designed as a descriptive cross sectional survey to determine women's perception of males' involvement in maternal healthcare in Rivers State, Nigeria. The population consisted of all 28, 294 pregnant and post-natal women registered in the Government Health Centres in the 23 LGAs in Rivers State (RSPHMB, 2012). A sample size of 300 women was selected, using multi-stage sampling technique. 6 LGAs were first selected from the 3 Senatorial Districts via simple random technique. 3 Health Centres per LGA area were further selected, using simple random technique. The sample size for each Health Centre was realized, using proportionate stratified random sampling technique. At the Health Centre, pregnant women and post-natal mothers were then purposively selected. The instrument for data collection was the questionnaire tagged *Women's Perception of Males' Involvement in Maternal Healthcare Questionnaire (WPMIMHQ).* The questionnaire items were structured, according to modified Likert rating scale. The instrument was validated and reliability determined at 0.86, using Cronbach-alpha method. The research questions were analyzed using mean, mean sets and rank order statistics, while z-test was used to test the hypotheses at 0.05 significant level.

Data Analyses

Research Question 1

What are the perceptions of educated women on the involvement of men in decision-making in maternal healthcare?

Table 1: Mean of women's perception of decision making in Maternal Healthcare

S/No	Assessed Variable	Primary	Post Primary	Mean Set	Position	Decision
1.	Discussion between couples on issues concerning pregnancy has an effect on the outcome of the pregnancy	3.6	3.6	3.6	1st	Accept
2.	Only the woman should decide where she would be attended to during and after the pregnancy	3.6	1.6	2.6	3rd	Accept
3.	Only the man should make decisions in serious cases such as operation.	1.8	1.7	1.8	5th	Reject
4.	Both the husband and wife should make decisions about the pregnancy.	3.8	3.7	3.8	2nd	Accept
5.	The woman should be allowed to make decisions on serious issues (operation) if the husband is not around	1.8	2.9	2.4	4th	Reject
	Aggregate Mean	**2.92**	**2.70**	**2.84**		

In Table 1, five variables were examined to determine women's perception of decision-making in maternal healthcare among women with primary and post primary education in Rivers State. The respondents with primary education agreed to all the items with mean scores of 3.6, 3.6, and 3.8, using the criterion mean of 2.5 and response position from 1st to 5th except items 3 and 5 where they disagreed with mean scores of 1.8 and 1.8 respectively. The respondents with post primary education agreed to all the items with mean scores of 3.6, 3.7 and 2.9 except items 2 and 3.

The aggregate mean scores of 2.92 and 2.72 respectively for respondents with primary and post primary education revealed the agreement that most of the items that communication between couples concerning pregnancy has an effect on the pregnancy; hence, both the husband and wife should make decisions concerning pregnancy. The woman should be able to make decisions on serious issues like operation in the absence of the man. On the other hand, they disagreed that decision-making should be left solely for either the man or woman.

Research Question 2

What are the perceptions of rural and urban women on men's determination of geographic accessibility to maternal health services?

Table 2: Mean of the perception of rural and urban women on men's determination of geographic accessibility to maternal health services.

S/No	Assessed Variable	Rural	Urban	Mean Set	Position	Decision
6.	Men only need to provide transport for their wives; they do not need to follow them to the clinic.	2.5	1.9	2.2	5th	Reject
7.	The choice of the clinic to be used should be based on the husband's place of work.	2.6	3.5	3.1	4th	Accept
8.	The choice of clinic should be based on the type of services offered not on distance.	2.9	3.5	3.2	3rd	Reject
9.	The choice of the clinic to be used should be based on the woman's convenience.	3.2	3.6	3.4	2nd	Accept
10.	Men should make provision for emergency transport, in case they are not around when the need arises.	3.6	4.1	3.9	1st	Reject
	Aggregate Mean	**2.96**	**3.32**	**3.16**		

In Table 2, five variables were used to examined rural and urban women's perception of men's determination of geographic accessibility to maternal healthcare in Rivers State. The respondents from rural areas agreed to all the items with mean scores of 2.5, 2.6, 2.9, 3.2 and 3.6, using the criterion mean of 2.5 and response position from 1st to 5th. The respondents from urban areas agreed to all the items with mean scores of 3.5, 3.5, 3.6 and 4.1, except item 6. The aggregate mean scores of 2.96 and 3.32 respectively for urban and rural respondents revealed their agreement to all the items that the choice of clinic should be based on the husband's place of work, the woman's convenience, the services offered and that emergency transport arrangements be made by the man. However, the women disagreed on the fact men do not need to accompany them to the clinic.

Research Question 3

What are the perceptions of employed and unemployed women on men's determination of economic accessibility to maternal health services?

Table 3: Mean and Rank Order of the perception of employed and unemployed women's on men determining economic accessibility to maternal health Services.

S/No	Assessed Variable	Unemployed	Employed	Mean Set	Position	Decision
11.	The choice of clinic to be used should be based on what the husband can afford and not on the services the woman requires.	1.9	1.8	1.9	5th	Reject
12.	It is not good for the woman to totally depend on the man for money during pregnancy.	3.1	3.1	3.1	2nd	Accept
13.	It is good for the husband to save money during his wife's pregnancy, in case complications needing operation arise.	1.8	3.2	2.5	4th	Accept
14.	It is good for a woman to do something that gives her money, so that she can contribute to the kind of care she desires during pregnancy.	3.4	3.3	3.4	1st	Accept
15.	There is no need for the woman to do something that gives her money, since the man provides for everything.	2.7	2.5	2.6	3rd	Accept
	Aggregate Mean	**2.58**	**2.78**	**2.70**		

In Table 3, five variables were examined to determine rural and urban women's perception of men's determination of economic accessibility to maternal healthcare among women from rural and urban areas in Rivers State. The unemployed respondents agreed to all the items with mean scores of 3.1, 3.4 and 2.7 respectively, using the criterion mean of 2.5 and response position from 1st to 5th except Items 11 and 13. The employed respondents agreed to all the items with mean scores of 3.1, 3.2, 3.3 and 2.5 except item 11.

The aggregate mean scores of 2.58 and 2.78 respectively for unemployed and employed respondents revealed that they agreed to all the items that it is not good for the woman to be idle or solely dependent on the man for money but rather earn a living for herself, in order to contribute to the kind of care she desires during pregnancy. They disagreed that the choice of clinic should be based on the services offered and not on what the husband can afford.

Research Question 4

What do women think of males' involvement in the utilization of maternal health services?

Table 2: Mean of the perception of women on males' involvement in the utilization of maternal health services.

S/No	Assessed Variable	Primary (Spouse)	Post Primary	Mean Set	Position	Decision
16.	It is important for men to come to the clinic from time to time to know about the condition of their wife's pregnancy.	3.4	3.2	3.2	3rd	Accept
17.	It is important for men to know about possible problems during pregnancy, so they can prepare for it.	3.4	3.7	3.6	2nd	Accept
18.	It is good for men to be with their wives during labour to offer them moral support	7.5	3.2	5.4	1st	Accept
19.	Women would rather prefer the support of older women to their husbands during labour.	2.5	2.6	2.6	5th	Accept
20.	It is important for men to know the needs of nursing mothers, so they can encourage them to attend mother-baby clinic.	3.2	3.2	3.2	4th	Accept
	Aggregate Mean	**4.00**	**3.18**	**3.60**		

In Table 4, five variables were examined to determine women's perception of males' involvement in the utilization of maternal healthcare services in Rivers State. Respondents with spouses with primary education agreed to all the items with mean scores of 3.3, 3.4, 7.5, 2.5 and 3.2, using the criterion mean of 2.5 and rank order from 1^{st} to 5^{th} . Respondents with spouses with post primary education agreed to all the items with mean scores of 3.2, 3.7, 3.2, 2.5 and 3.2.

The aggregate mean scores of 4.00 and 3.80 for spouses of respondents with primary and post primary level of education respectively agreed to all the items on the importance for the man to be at the clinic to know and plan for possible complications and provide moral support during labour and after-birth.

Hypothesis 1

There is no significant difference between the perceptions of women with primary education and women with post primary education on decision-making in maternal healthcare.

Table 5: z-test on the difference between the perceptions of women with primary and post-primary education on decision-making in maternal healthcare

Categories	N	X	S.D	df	z-calculated	z-Critical	Decision
Primary	83	2.92	0.6354	298	0.198	1.96	Accepted
Post primary	127	2.70					

Table 5 shows that women with primary education have a mean and standard deviation scores of 2.92 and 0.64 respectively and women with post primary education have a mean and standard

deviation scores of 2.70 and 0.64 respectively. With a degree of freedom of 298 at an alpha level of 0.05, the calculated z-value is less than the critical z-value. Therefore the null hypothesis was accepted. Hence, there is no significant difference between the perceptions of women with primary and post primary levels of education on joint-decision making in the family.

Hypothesis 2

There is no significant difference between the perceptions of women in rural and urban areas regarding men determining geographic accessibility to maternal health care.

Table 6: z-test on the difference between the perceptions of women in rural and urban areas regarding men's determination of geographic accessibility to maternal healthcare

Categories	N	X	S.D	df	z-calculated	z-Critical	Decision
Rural	86	2.96	0.7634	298	0.175	1.96	Accepted
Urban	214	3.32					

Table 6 shows that women from the rural areas have a mean and standard deviation scores of 2.96 and 0.76 respectively, while women from urban areas have a mean and standard deviation scores of 3.32 and 0.76 respectively. With a degree of freedom of 298 at an alpha level of 0.05, the calculated z-value is less than the critical z-value. Therefore the null hypothesis was accepted. By implication, there is no significant difference between the perceptions of rural and urban women on the role of men in determining geographic accessibility to maternal healthcare.

Hypothesis 3

There is no significant difference in the perception of employed and unemployed women with regard to men's determination of economic accessibility to maternal healthcare.

Table 7: z-test on the difference between the perceptions of women who are unemployed and women who are employed regarding men determining economic accessibility to maternal healthcare

Categories	N	X	S.D	df	z-calculated	z-Critical	Decision
Unemployed	70	2.58	0.6553	298	0.200	1.96	Accepted
Employed	230	2.78					

Table 7 shows that unemployed women have mean and standard deviation scores of 2.53 and 0.66 respectively, while employed women have a mean and standard deviation scores of 2.78 and 0.66 respectively. With a degree of freedom of 298 at an alpha level of 0.05, the calculated z-value is less than the critical z-value. Therefore the null hypothesis was accepted. By implication, there is no significant difference between the perceptions of unemployed women from employed women on the role of men in determining economic accessibility to maternal healthcare.

Hypothesis 4

There is no significant difference between the perceptions of women whose spouse have primary education and those whose spouses have post primary education regarding males' involvement in the utilization of Maternal Health Services.

Table 8: z-test on the difference between the perceptions of women whose spouse have primary education and those whose spouse have post primary education regarding males' involvement in the utilization of maternal health services.

Categories	N	X	S.D	df	z-calculated	z-Critical	Decision
Primary	53	3.98	0.4662	298	1.9802	1.96	Reject
Post Primary	247	3.74					

Table 4.3.4 shows that women whose spouses had primary education have a mean and standard deviation scores of 3.98 and 0.47 respectively and women whose spouses had post primary education have a mean and standard deviation scores of 3.74 and 0.47 respectively. With a degree of freedom of 298 at an alpha level of 0.05, the calculated z-value is greater than the critical z-value. Therefore the null hypothesis was rejected. By implication the alternative hypothesis was accepted, hence there is a significant difference between the perceptions of women whose spouses have primary education and those whose spouses have post primary education on the uptake and utilization of skilled maternal health services.

Discussion of findings

The findings of the study revealed that that joint decision-making was a vital part of maternal process and men needed to be involved in. The knowledge made available to men concerning female reproduction was limited. As such, they were unable to communicate effectively with women candidly. Communication among couples on vital issues such as where to access antenatal services and what to do in the event of emergencies and decisions jointly taken had the most positive responses. This is in keeping with NIPORT's (2009) study in Bangladesh which stated that the husband's only decision-making was negatively associated with accessing antenatal services.

The study further revealed that although women acknowledged the efforts of their husbands in providing and arranging transport to healthcare facilities, they preferred the physical presence of their spouse at the health facility with them. On the question item of choice of facility, based on type and quality of services offered, the study by Thaddeus & Maine (1994) confirmed the result of this study that rural women preferred convenience to the quality or type of services offered, while those in urban areas preferred quality over distance or convenience. Thaddeus & Maine, in their study, asserted that the triple factors of distance, cost and quality were determined by the severity of illness in most cases.

Furthermore, respondents in the study, irrespective of their demographic characteristics, strongly held the opinion that male's involvement in maternal healthcare should include economically empowering them and granting them autonomy to be able to determine and contribute to the quality of care she desires. Ahmed (2010) asserted that economic ability was also central to all the factors of decision-making, distance and accessing to and uptake of quality and skilled maternal services.

Several factors have been shown to be responsible for women not utilizing maternal health services. They included parity, availability of transport to health facility, level of education of mother and that of spouse and the cost of accessing skilled birth attendants (Kimani, et al, 2015).

This study agreed with the foregoing findings in that women, whose spouses had primary level of education and below, preferred the support of older women, who were most likely to take deliveries at home and not at a health facility. The researchers further noticed the similarity of their findings with those of Kimani et al (2015) on the knowledge of the danger signs of pregnancy to be lower among the research subjects whose husbands had primary education and below. Men should be involved in maternal care to know about delivery complications so as to intervene and insist that their wives used skilled healthcare. It is not only important for women to be educated, but the education of their spouse will go a long way in providing the needed support they require in accessing and utilizing skilled maternal services.

The tests of hypotheses showed no significant difference between the perceptions of women with primary or post primary education, those who reside in rural or urban areas; unemployed or employed women on decision-making and men determining geographic and economic accessibility to maternal healthcare. There was however a difference in the perception of women with primary education and those with post primary education on men determining utilization of maternal health services in keeping with earlier discussions.

CONCLUSION

The study concluded that women appreciate the role of males' involvement in maternal healthcare, albeit currently fraught with challenges such as culture, physical set-up of clinics, lack of staff training, resources needed to engage men effectively, and ill-timing of clinic hours, particularly for working men. They desired to be empowered with education and the means to earn and control their resources, because they appreciated the fact that despite the good intentions of their spouse in encouraging and supporting them, certain extraneous factors might hinder them from doing so. A woman empowered with education, resources and opportunities would go ahead to make the best decisions concerning her health and that of her family by extension.

RECOMMENDATIONS

1. Women empowerment in terms of education, economically and socially would go a long to enhance their quality of life.
2. Policy makers should ensure an updated review of policies concerning men and maternal health, in order to make their policies realistic and measurable.
3. Training of health workers and mass media campaigns on the relationship between gender and health is required, so as to get the full benefits of a healthy family and society in general.

REFERENCES

Ahmed, S. et al. (2010). Economic status, education and empowerment: Implications for maternal health service utilization in developing countries. *PlosOne* 5(6). 1-6.

Ampim, G. A. (2013). Men's involvement in Maternal Healthcare in Accra, Ghana: From Household to Delivery Room. *Master of Philosophy Dissertation. Faculty of Psychology. Department of Health Promotion.* Universitas Bergensis.

Davis, J., Luchters, S & Holmes, W. (2012). *Men and maternal and newborn health: Benefits harms, challenges and potential strategies for engaging men*. Compass. Women's and Children's Health Knowledge. Hub: Melbourne.

Harrison, K. A. (1997). Maternal mortality in Nigeria: The real issues. *African Journal of Reproductive Health*. 2 *(1)*:7–13.

Kimani, H., Farquar, C., Wanzala, D., Ng'ang'a, Z. (2015). Determinants of Delivery by Skilled Birth Attendants among Pregnant women in Makueni County, Kenya. *Journal of Public Health Research.* 5 *(1)*: 1- 6. Doi:10.10.5923/jphr.20150501.01

Kramarae, C. (1992) "The condition of Patriarchy" in Kramarae Cheris and Spender Dale (eds.) The Knowledge Explosion: Generation of Feminist Scholarship. Athen Series, eachers College Press, London.

National Demographic and Health Survery. (2008). Maternal Mortality. Federal Republic of Nigeria. Retrieved from http://www.ndhs.ng.gov. Accessed on the 9th of October, 2014

National Institute of Population Research and Training (NIPORT), Mitra and Associates & Macro International. (2009). *Bangladesh Demographic and Health Survey 2007*. Dhaka, Bangladesh and Calverton, Maryland, USA.

Nkungula, C. (2007, Sept. 4). *Malawi: Men – architects of change in promoting maternal Health*. The Chronicle Newspaper – Lilongwe, Malawi.

Nwokocha, E. E. (2008). Maternal crises and the role of African men: The case of a Nigerian Community. *African Journal of Population Studies* 22 *(1)*.

Rivers State Primary Healthcare Management Board. (2012). Annual Report. Retrieved from www.rsphmb.org. Accessed on the 2nd of January 2015.

Thaddeus, S. & Maine, D. (1994). Too far to walk. Maternal Mortality in context. *Journal of Soc. Sci. Med.* 38 (8): 1091 – 110.

United Nations Population Fund. (1996). Population and development, Program of Action adopted at the International Conference on Population and Development (ICPD), Cairo, 5–13 September 1994 Volume 1.New York, United Nations, 1995: paragraph 4.27 (ST/ESA/SER.AS/149).

WHO. (2007). Maternal mortality in 2005. Estimates developed by WHO, UNFPA, and the World Bank. Retrieved at www.who.org. Accessed on the 11th of December 2014.