academicJournals

Vol. 5(6), pp. 262-270, June 2013
DOI: 10.5897/JPHE2013.0505
ISSN 2006-9723 ©2013 Academic Journals
http://www.academicjournals.org/JPHE

Journal of Public Health and Epidemiology

Full Length Research Paper

Perception, attitude and involvement of men in maternal health care in a Nigerian community

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Accepted 6 May, 2013

This study aimed to examine men's perception, attitude and involvement in maternal care. A cross-sectional descriptive survey was carried out in Atelewo community in Osogbo, Osun State, Nigeria using multi-stage sampling technique to select 400 respondents. Participants were adult men of reproductive age. Data were collected using semi-structured questionnaire. In the study, there was no intervention component; and main outcome measures were perception of men about maternal health, attitude of men to maternal health and involvement of men in maternal care. Results revealed majority of the respondents 225 (62.2%) were within the age group 20 to 39 years with a mean age of 36.3 years ±10.86. Most of them were skilled workers 144 (39.8%) and many 147 (40.6%) had post primary school education. One hundred and eighty-six (51.5%) of the respondents had poor knowledge while 205 (56.5%) had a good attitude towards maternal health care. Concerning the involvement of the men in maternal health care of their wives, about a quarter 62 (29.1%), 87 (24.0%), 98 (27.1%) ever followed their wives to family planning clinic, ante-natal clinic and the delivery room respectively. Thus, the level of awareness of men about maternal heath was high, but their involvement in giving care was poor and only about half of them had good attitude towards maternal health care. Education and awareness programs should therefore be carried out by governmental agencies, non-governmental organizations and other voluntary groups to address involvement of men in maternal health care.

Key words: Perception, attitude, involvement, maternal health, reproductive health, men, women.

INTRODUCTION

Maternal health refers to the broad apparent and currently accepted means of providing promotive, preventive, curative and rehabilitative health care for mothers (Lucas and Gilles, 2003). It refers to health of women during pregnancy, childbirth and postpartum period and it is a very important component of reproductive health. Maternal health in developing countries and economically restrained settings remains a daunting and largely unmet global public health challenge (Taiwo et al., 2007). Progress has been slow and some countries with high maternal mortality are experiencing stagnation or even reversals (WHO, 2000; WHO, 2006) with countries in sub-Saharan Africa, including Nigeria being the hardest hit (UNICEF, 2006; NPC, 2004). Nigeria has one of the worst maternal health indicators in the world (Joseph et al., 2009; Federal Ministry of Health

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2003; Jose, 2010), however current progress in maternal mortality ratio reveals 32% reduction from 800 to 545 deaths per 100,000 live births (Jose, 2010). Over the years, the issue of maternal health has been predominantly seen and treated as a purely feminine matter. The hugely disproportionate representation of men, and their resulting dominance, among those responsible for the planning and provision of health care, has had serious consequences for the health status of women and girls, particularly in developing countries (Taiwo et al., 2007). 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 role in such matters. However, the 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 (Drennon, 1998).

In most African countries, maternal health issues which include family planning, pregnancy and childbirth have long been regarded exclusively women's affairs (Mullick et al., 2005). Although the health of mothers are determined by many factors including socio-economic status and environmental factors, one important and crucial factor that has been neglected over the years is the role of men as a determinant of health of mothers (Mullick et al., 2005).

Men's involvement in reproductive health is crucial, though their participation has been poorly demonstrated. Factors responsible for this include culture, religion, ignorance and socio-economic factors. Men are the primary decision makers of most families in developing countries, as such their involvement in maternal health issues could promote a better relationship between couples in the family and enhance maternal wellbeing (Mullick et al., 2005). It has been observed that men's involvement in maternal health is a promising strategy for promoting maternal health (Cohen et al., 2000; Mullay et al., 2005) observed that involving husband/partner and encouraging joint decision-making among couples may provide an important strategy in achieving women's empowerment; this will ultimately result in reduced maternal morbidity and mortality. It has also been observed that men's behavior and involvement in the maternity care of their pregnant partners can significantly affect the health outcomes of the women and babies (Stycos, 1996). Men could be involved in maternal health care in the following ways: supporting contraceptive use by women, helping pregnant women to stay healthy, arranging for skilled care during delivery, avoiding delays in seeking medical care, helping after the baby is born, and being responsible fathers (effective parents) (Joseph et al., 2009).

In Nigeria, where culture has been shown to be an important factor influencing relation to women's access to available reproductive health facilities, there is paucity of data on men's views with regard to maternal health (Yahaya, 2002; Wall, 1998). This study, therefore, aimed to assess the perception, attitude and involvement of men in maternal health care. This will help in understanding men's disposition and serve as a guide in designing targeted programs.

MATERIALS AND METHODS

This descriptive cross-sectional study was conducted amongst men. The study location is the Atelewo community in Osogbo, the capital of Osun State, located in the southwestern part of Nigeria and is dominated by the Yoruba speaking ethnic group. The study population included adult males from the age of 18 years upwards residing within the Atelewo community. A systematic random sampling technique was used to select households, and every male aged 18 years and above in the selected households who gave verbal consent was included in the study.

Four hundred pre-tested, semi-structured questionnaires were either self administered when the respondents could read or administered by interviewers when respondents were not able to read. Section A of the questionnaire covers socio-demographic status of respondents (that is, age, educational level, occupation, religion, tribe); Section B covers respondents knowledge on maternal health care [awareness and meaning of various maternal health care services such as antenatal care (ANC), family planning (FP) and post natal services (PNC)]; Section C includes attitude to maternal health care services (Agreeing, indifferent or disagreeing on issues related to men supporting their wife on maternal health care services); Section D covers involvement of respondents in maternal health care services (previous involvement in various maternal health services such as ANC, FP and PNCs).

Proctors who guide the questionnaire administration were trained medical students. Pre-testing and question validation was performed in Offatedo Community, Egbedore Local Government Area of Osun State.

Measurement of outcome measures

The questions on attitude and involvement of the respondents about maternal health services were scored. Attitude and individual involvement was calculated. Those with wrong responses are scored 0 while those with right responses are scored 1. Respondents who score below the mean were regarded as having poor knowledge, negative attitude or poor involvement in maternal health services as the case may be while those with scores up to or above the mean were regarded as having good knowledge, attitude or involvement.

Data analysis

The data were analyzed using Statistical Package for Social Sciences (SPSS) version 16. Chi-square was used to test for statistical significant associations between categorical variables and the level of significance was set at 0.05.

Ethical considerations

Ethical clearance was obtained from the Ethical Committee,

Table 1. Socio-demographic characteristics of respondents (n=362).

Socio-demographic characteristics	Frequency	Percentage
Age group (years)		
<20	7	1.9
20-39	225	62.2
40-59	114	31.5
60 and above	16	4.4
Marital status		
Single	69	19.1
Married	281	77.6
Divorced	5	1.4
Widowed	7	1.9
Occupation		
Unemployed	40	11.2
Unskilled	114	31.7
Skilled	144	39.8
Professionals	63	17.43
Educational status		
No formal education	11	3.0
Primary education	60	16.6
Secondary education	144	39.8
Tertiary education	147	40.6
Religion		
Christianity	174	48
Islam	186	51.4
Others	2	0.6
Ethnicity		
Yoruba	354	97.8
Igbo	8	2.2
Hausa	0	0.0

LAUTECH Teaching Hospital, Osogbo, and verbal informed consent was sought from each respondent. Only those who consented were included in the study.

RESULTS

Socio-dermographic status of respondents

Majority of the respondents 225 (62.2%) were within the age group 20 to 39 years with a mean age of 36.3±10.86 years. Most of them were married 281 (77.6%), skilled 144 (39.8%), had post secondary education 147 (40.6%), Muslims 186 (51.4%) and of the Yoruba tribe 354 (97.8%) (Table 1).

Perception about maternal health care (MHC) among respondents

Most of the respondents 358 (98.9%) were aware of the need for maternal health care. Majority 345 (95.3%) had heard of family planning before, and many of those that were aware understood it to mean control of family size 130 (37.7%) and child spacing 120 (34.8%). Of the 345 who had heard about family planning before, 309 (89.5%) knew that men had a role in family planning and 281

Table 2. Awareness and knowledge of respondents on maternal health care (MHC).

Variable	Frequency	Percentage
Aware women need special care (n=362)		
Yes	358	98.9
No	4	1.1
Ever heard of family planning (n=362)		
Yes	345	95.3
No	17	4.7
Meaning of family planning(n=345)		
Control of family size	130	37.7
Child spacing	120	34.8
Prevent unwanted pregnancy	95	27.5
Men's role in family planning(n=345)		
Consent	64	18.6
Support	281	81.4
Contraceptive methods for men (multiple response; n=362)		
Vasectomy	70	19.3
Male condom	338	93.4
Injectables	226	67.9
Diaphram	46	13.8
Ever heard of ANC (n=362)		
Yes	340	93.9
No	22	6.1
What ANC entails (n=340)		
Taking care of pregnant women and their fetuses	268	78.8
Giving drugs and injection to pregnant women	41	12.1
Detecting and managing complication	31	9.1
Men's role in ANC (n=340)		
Financial support	99	29.1
Encouraging and reminding her	104	30.6
Providing emotional and moral support	137	40.3
Men should ensure skilled hands for delivery (n=362)		
Yes	355	98.1
No	7	1.9
Reasons for ensuring skilled hands for delivery (n=355)		
Good health of mother	23	6.5
Proper care of mother	48	13.5
Safe delivery	145	40.8

Table 2. Cont'd.

Avoid complications	139	39.2
Know wife needs care and support after delivery(n=362)		
Yes	360	99.4
No	2	0.6
Awareness of exclusive breastfeeding(EBF) (n=362)		
Yes	261	72.0
No	101	28.0
Understanding of EBF(n=362)		
Breast milk alone	265	73.2
Breast milk with little water	97	26.8
Duration of EBF(n=362)		
<6	79	21.8
6	199	55.0
>6	84	23.2

(81.4%) understood the role to be supportive. Respondents were asked an open ended question about male specific contraceptive methods, majority, 338 (93.4%) knew male condoms followed by injectables 226 (67.9%), 70 (19.3%) knew vasectomy with the diaphragm being the least known 46 (13.8%) contraceptive. In addition, most of the respondents 340 (93.9%) had heard of ANC. Some of those who had heard about ANC believed it entails taking care of pregnant women and their unborn child 268 (78.8%) while others believed it involves giving drugs and injections to pregnant women 41 (12.1%) and managing/detecting complications 31 (9.1%). Many 137 (40.3%) saw their role as providing emotional and moral support while some 99 (29.1%) felt financial support is their only role. Also majority of the respondents 348 (96.1%) believed that men had a role to play in deciding where their wives delivered and 355 (98.1%) knew they should ensure their wives were delivered by skilled birth attendants. The main reasons given for ensuring skilled hands at delivery were to ensure safe delivery 145 (40.8%) and to avoid complications 139 (39.2%). Also, 360 (99.4%) knew their wives needed care and support from them after delivery. An appreciable number of respondents 265 (73.2%) understood what exclusive breastfeeding (EBF) meant and 199 (55.0%) were knowledgeable about the correct duration of six months. After the scoring of outcome variables, 186 (51.4%) and 176 (48.6%) of the respondents had poor and good comprehensive knowledge about maternal health care (MCH) respectively (Table 2).

Attitude of respondents to maternal health care (n=362)

Table 6 shows the attitude of respondents towards maternal health care. Most of the respondents 333 (93.1%) agreed that men should encourage pre-conception care, encourage family planning 308 (85.1%) and that men should support exclusive breast feeding 338 (93.4%). However, 156 (43.1%) still felt that family planning encourages promiscuity. The outcome variables for attitude were scored, and 157 (43.4%) were found to have negative attitudes, while 205 (56.6%) had positive attitudes towards maternal health care (MCH) (Table 3).

Involvement of respondents in maternal health care

The wives of 193 (53.2%) respondents had used family planning (FP) methods before, but only few 105 (29.0%), 87 (24.0%), 98 (27.1%) had ever followed their wives to family planning clinics, antenatal care and to the labour room respectively. The categorized involvement of men in maternal health care after scoring of the outcome variables showed that 194 (53.6%) had poor involvement, while 168 (46.4%) had good involvement (Table 4).

Association between socio-demographic characteristics of respondents towards perception, attitude and male involvement in maternal health

The categorized knowledge about MHC was found to be

Table 3. Attitude of respondents to maternal health care (n=362).

Variable	Frequency (Percentage)		
	Agree	Indifferent	Disagree
Men should encourage pre conception care	333(93.1)	8(2.2)	17(4.7)
Men should encourage FP	308(85.1)	7(1.9)	47(13.0)
FP encourages promiscuity	156(43.1)	71(19.6)	135(37.3)
FP could lead to infertility	118(32.6)	108(29.8)	136(37.6)
Men should follow their wives for ANC	231(63.8)	39(10.8)	92(25.4)
ANC encourages gossip	71(19.6)	57(15.7)	233(64.4)
ANC encourages promiscuity	65(18.0)	42(11.6)	255(70.4)
Men should provide finances for ANC	330(91.2)	6(1.7)	26(7.2)
Men should decide place of delivery	347(95.9)	15(4.1)	0(0.0)
Men should be present in labour room	147(40.6)	52(14.4)	163(45.0)
Men should assist with house chores	288(79.6)	25(6.9)	49(13.5)
Men should ensure child complete immunization	353(97.5)	6(1.7)	3(0.8)
Men should support EBF	338(93.4)	12(3.3)	12(3.3)
Breast milk alone is not sufficient for children <6 months	170(47.0)	21(5.8)	171(47.2)
Herbal concoction is needed to prevent childhood illness	131(36.2)	19(5.2)	210(58.0)

Table 4. Involvement of respondents in maternal health care.

Variable	Frequency (percentage)	
	Yes	No
Wife ever used family planning (n=362)	193(53.2)	169(46.8)
Informed by wife before use of FP (n=362)	249(68.8)	113(31.2)
Gave consent before wife used FP (n=362)	234(64.6)	128(35.4)
Followed wife to FP clinic (n=362)	105(29.0)	257(71.0)
Wife currently on FP (n=362)	157(43.4)	205(56.6)
Allow wife to attend ANC (n=362)	353(97.6)	9(2.4)
Ever followed wife to ANC (n=362)	87(24.0)	275(76.0)
Ever followed wife to labour room (n=362)	98(27.1)	264(72.9)
Aware of the immunization status of your child(ren) (n=362)	302(84.3)	60(16.6)
Children were exclusively breast fed for 6 months (n=362)	263(72.6)	99(27.4)
Will follow wife to delivery room next pregnancy (n=362)	190(52.4)	172(47.6)

significantly associated with the respondents' marital status (p = 0.039), with the ever married having a better knowledge than the single. The involvement of men in maternal health care was also found to be significantly associated with the respondents' age (p = 0.0001), marital status (p = 0.0001) and occupation (p = 0.009), such that those older than 40 years, ever married and professionals were more involved in maternal health care (MCH). The categorized attitude was found to be significantly associated with the occupation (p = 0.015) and educational status (0.001) of the respondents, with professionals and those with tertiary education having more positive attitude (Table 5).

DISCUSSION

The study demonstrates key issues in respect of perception, knowledge, attitude and involvement of men in maternal health care in a Nigerian community. The demographic pattern shows that majority of the respondents (62.2%) were found within the age groups of 20 to 39 years; this meant that most men in Atelewo community were still within their active reproductive years. In most Nigerian communities, the population structure reflects a preponderance of young persons with only a small proportion of the elderly and aged, indicative of a population with high fertility (National Population Commission, Federal Republic of Nigeria, Nigeria Demographic and Health Survey, 2003). The educational status of men in the community can be considered to be more than average since most (about 80%) of them had at least secondary school education. In contrast, in Nigeria, only 72.5% of men were found to be literate. Globally, more than half a million women still die annually

Table 5. Association between attitude towards male involvement in maternal health care and socio-demographic characteristics of respondents (n=362).

Variable	Attitude (%)		X^2	p-value
	Poor	Good		
Age group				
<40	99(64.7)	127(63.8)	0.030	0.863
40 and above	54(35.3)	72(36.2)		Not significant
Marital status				
Single	27(17.6)	38(19.1)	0.121	0.728
Ever married	126(82.4)	161(80.9)		Not significant
Occupation				
Skilled	58(38.4)	81(41.3)	10.466	0.015
Unskilled	61(40.4)	50(25.5)		Significant
Unemployed	12(7.9)	24(12.2)		-
Professionals	20(13.2)	41(20.9)		
Educational status				
No formal education	9(5.9)	2(1)	15.569	0.001
Primary education	26(17)	33(16.6)		Significant
Secondary education	70(45.8)	68(34.2)		-
Tertiary education	48(31.4)	96(48.2)		
Religion				
Christianity	72(47.1)	102(51.3)	1.825	0.402
Islam	80(52.3)	97(48.7)		Not significant
Others	1(0.7)	0(0.000)		-
Income grouping				
<18,000	32(30.5)	44(29.5)	0.026	0.871
18,000 and above	73(69.5)	105(70.5)		Not significant

as a result of complications of pregnancy and childbirth (WHO, 2005). A disproportionately high burden of these deaths is borne by developing countries, including Nigeria. With maternal mortality ratio of 1,500 per 100,000 births and an estimated 55,000 deaths annually, Nigeria accounts for nearly 10% of the global estimates of maternal mortality (Adetoro, 1987). In order to address this disturbing trend, the International Conference on Population and Development (ICPD) urged that special efforts be made to emphasize men's shared responsibility and promote their active involvement in maternity care (UNFPA, 1995). Almost all the respondents (98.9%) from this study were aware of the need for maternal health care and 4 out of 10 believed that provision of basic needs is an important role of men in maternal health care. This corroborates other studies on men's role of caring in maternal health (Stycos, 1996; Berer, 1996; Helzner (1996). Similar studies on the participation of men in maternal care have been reported mostly from southern part of Nigeria (Odimegwu et al., 2005). Odimegwu et al. (2005) reported a high level of awareness and participation of men in maternity care in Osun State.

The promotion of family planning, so that women can avoid unwanted pregnancy, is central to the World Health Organization (WHO) work on improving maternal health and is core to achieving the Millennium Development Goal (Morhason-Bello et al., 2008). Family planning being one of the essential interventions in improving maternal health is known by majority of the respondents and nearly all of them accepted that men have roles to play in family planning. These findings are similar to previous studies on male participation in reproductive health in Ghana (Berer, 1996; Helzner, 1996; Male Participation in Reproductive Health, 1998).

Also half of the respondents agreed that men should be involved in pre-conception care and also encourage family planning; this corroborates other previous studies

that has been carried out in South Africa (Mullick et al., 2005; Population Reports, 1998).

Findings on family planning involvement might be attributed to increase awareness of family planning services and methods as a way of promoting maternal and child health and the gradual and progressive acceptance of it by men generally.

Men being critical partners for the improvement of maternal health and reduction of maternal mortality can be clearly demonstrated in the area of antenatal care (ANC) of which their social, emotional and economical inputs cannot be underestimated. ANC awareness of the respondents were very encouraging, nearly all of them demonstrated a high level of awareness. About attitude towards antenatal care, nearly half of the respondents agreed that men should accompany their wives for antenatal care visit, with a similar finding about the role of partners during maternity in a study on involving men in maternity care (Andrews, 2012). However only 2 out of 10 respondents follow their wives for antenatal care visits and also to the labour ward, findings which are in keeping with other studies (Mullick et al., 2005; Britta, 2005).

Men's presence and their participation at the health facilities during antenatal care visit of their wives will help boost the morale of their wives and also bring about a greater sense of commitment of both parents to having healthy mothers and babies as evident from other studies (Mullick et al., 2005; Cohen et al., 2000; Mullay et al., 2005; Stycos, 1996).

Perception of ANC amongst respondents showed that about four-fifth believed it entails taking care of pregnant women and their unborn child while few believed it involves giving drugs and injections to pregnant women and detecting complications. However less than half of the respondents saw their role as providing emotional and moral support while 2 out of 10 felt financial support is their only role, these findings are not in keeping with the general expectations of men described in other studies (Joseph et al., 2009; Mullick et al., 2005; Cohen et al., 2000; Mullay et al., 2005). This therefore stresses the need to target men for enlightenment programs about maternal health care, and to involve men in the design and implementation of maternal health services.

Postnatal care is one of the most important maternal health-care services for not only prevention of impairment and disabilities but also reduction of maternal mortality. In line with perception to delivery and post-natal care, nearly all the respondents believed they had a role to play in deciding where their wives deliver, ensuring that their wives were in skilled hands for delivery and also in the aspect of them giving the necessary care and support after delivery and during peuperium. These findings were similar to the outcome of the research on men in South Africa and maternity care (Ezeh et al., 1996). This pattern is encouraging and further underscores the need for men to be more involved in the design and implementation of maternal health services.

Professionals and those with tertiary education were also found to have better attitude towards MHC than the others. This pattern has been similarly reported by earlier studies and it may not be difficult to understand. The knowledge and involvement in MHC was found to be associated with marital status with the ever married having better knowledge and involvement in MHC than the singles, and this also is easy to understand. It however raises the need to begin educational programs about MHC early, even before the men get married.

Maternal deaths are still high in developing countries most especially in Nigeria, the cause of which is multi-factorial. Maternal health care has been seen to be more of a feminine affair with women being at the receiving end of unfavorable pregnancy and delivery outcomes. Men's role in maternal health care is cardinal and of great importance in the attainment of MDGs 4 and 5; reducing child mortality and improving maternal health, respectively.

CONCLUSION AND RECOMMENDATION

The knowledge and attitude of respondents towards maternal health care were average, and their involvement in the health care of their wives was low as almost a quarter of respondents had ever followed their wives to family planning clinics, antenatal clinics and delivery rooms. This still shows that men lag behind in their responsibilities in improving maternal health.

Enlightenment programs should therefore be carried out by governmental agencies, non-governmental organizations and other voluntary groups and religious bodies to stress the involvement of men in promoting maternal health care and also being agent of change in improving the quality of life of women as it relates to maternal health thereby bringing about healthy families and indeed healthy nation.

ACKNOWLEDGEMENTS

The authors wish to acknowledge the cooperation of the members of staff of the Population Commission in Osun State for helping the researchers in providing necessary information; also the medical students who helped in the data collection.

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