International Journal of Humanities & Social Science: Insights & Transformations
Vol. 6, Issue 2 – 2021
ISSN: 2581-3587

A Review of Gender and Patriarchy as Proximate Determinants in Maternal Health Seeking Behaviour

Ayoola Adekunle Dada[1]

[1]*Department of General Studies, School of Business Studies, Federal Polytechnic, Ado-Ekiti, Ekiti State, Nigeria.*

Abstract

Universally, maternal healthcare system is an important segment of medical system in any society; this is as a result of the importance of mothers in the overall sustenance of human society. Despite the significance of maternal health care, however, there is an increasing gap between the developed countries and the developing countries in terms of levels of morbidity and mortality and mothers' survival at prenatal, delivery and postnatal periods. Across the globe, millions of women suffer from poor reproductive health and serious pregnancy related illnesses and disability and yearly the rate at which women die from complications of pregnancy and childbirth is alarming. Most of the deaths occur in Asia, but the risk of dying is highest in African countries. Patriarchal practices can be viewed as one of the leading reasons for the poor maternal health situation in Nigeria. Many have observed that traditional African culture has not been fair to women. Gender as entrenched in Culturaldictates, shapes behaviours; one's environment affects her reproductive attitudes, perceptions and motivations. The use and non-use of health services are determined by one's socio-cultural environment, which, in most cases, is shaped by its patriarchal structure.This paper attempts a review of existing literatureon gender and patriarchy as proximate determinants on maternal health-seeking behaviour especially in Nigeria and Sub-Sahara Africa at large with the aim of closing the gap in knowledge and understanding of maternal health.As a means of methodology, related existing literatures were sourced to facilitate this review. The review shows that gender and patriarchy like the two sides of a coin, though different but inseparable to a large extent, determines the actions and inactions of women of child bearing age as regards their health seeking. Conclusively, the paper suggests that policy makers and maternal health advocates should embark on policies and advocacies that will enhance the new normal of discouraging the harmful traditional gender and patriarchal practices that could hinder healthy maternal health seeking.

Keywords: Gender, Patriarchy, Maternal-Health, Behaviour.

Introduction

A review of previous efforts to understand similar or related phenomena is very crucial to the success of any social research. This review presents a systematic review of various researches and studies that sought to have a broad understanding of the information available about the variables of interest on gender and patriarchy as it affects maternal health seeking behaviour particularly in Nigeria and Africa as a whole. General information is supported by findings from empirical studies and perceived gaps in the information available are discussed. The factors

The review provides information on gender and patriarchy as proximate determinants of maternal health seeking behaviour and by extension the consequences on health of women of reproductive age especially within the African context and Nigeria in particular.

Patriarchy

Patriarchal practices can be viewed as one of the reasons for the poor maternal health situation in Nigeria. Many have observed that traditional African culture has not been fair to women. Women stand to be victims of injustice in traditional culture not because of what the society did to them, but due to what the society did not do to them [1]. However, this author like many others are of the opinion that injustices suffered by today's women and girls are from both angles. The traditional system defined the roles which both men and women should play in the family as well as in the community. On the one hand, boys were to grow up knowing that they were expected to be strong and hardworking, so as to be able to take care of their wives. While girls, on the other hand, were to be concerned with domestic activities and to be submissive. Women's success and happiness to a large extent will be determined by the husbands they were to marry, not the women themselves. Thus, they were robbed of every initiative and resourcefulness, which could enable them, to make decisions affecting them and the family generally.

Regarding maternal health, a number of cultural practices abound in different African countries which militate against women and their health, a study of Ibani people of Rivers State in Nigeria revealed that pregnant women are prohibited from coming out of their homes during a popular (Nwaotam) festival, which lasts for three days, notwithstanding their conditions [2]. If there is a violation, the consequences range from inflicting severe injury up to death of the woman or girl.

There are also nutritional taboos for pregnant women. For instance, most of the Yoruba community and other areas of Nigeria, pregnant women are forbidden from eating snails in spite of the rich protein content which they and the foetus greatly need at such time. There are other unhealthy practices which are found in other parts of the region, which are also applicable to other parts of Africa. For instance, cases of female genital mutilation are found in different parts of the State; while wife battery are equally reported, not just in Nigeria but in Uganda and other parts of Africa and beyond [1]. Rape, which is also a common practice in several parts of the world, this occurs in every thirty-six seconds in South Africa [1]; just like widow inheritance is

not uncommon in parts of Africa so also is for teenage girls to be married off by force. The afore-mentioned practices have untold consequences on maternal health.

Patriarchy seen in the light of wholesome inequity has been perceived as an over-arching category of male dominance [3], a situation carefully sustained by men through ages. While it has been claimed by some men that such gender relationship is responsible for peace at homes and the society generally, scepticism and suspicion about the genuineness of such assertion among women and the likely consequent breakdown in spousal/household communication can have indirect impact on maternal health seeking. However, the tendency is high for couples that lack confidence in themselves to seek assistance from other people. The consequence in the long run is that the intimacy and agreement that should necessarily follow decisions on maternal health care seeking are lost.

The pervasiveness of patriarchy as a system that does not discriminate against either patrilineal or matrilineal societies, but conceived in terms of the difference in magnitude of its application to both societies have been highlighted. It was argued that men are always in control of the myth system, even in matrilineal societies [4]. Ottong [5] expressed the same view by stating that the male plays a very dominant role in the social structure; he is, as a matter of right, the head of the family, and is seen and regarded in certain circumstances by the wife (or wives) as the lord and master whose decision is always final. Even in the exceptionally few matrilineal societies, authority relations are still patriarchal, although patterns of descent and inheritance might be governed by the principles of matrilineal [5].

Never the less, consciousness about the consequences of male dominance on women folk for the past few decades has been increasing and appears to be waxing stronger by the day. It was opined that the principle, which regulates the existing social relations between males and females, is not only wrong in itself, but also one of the chief hindrances to human development. It was also observed that such principle should be replaced by an alternative, which will be embedded in perfect equality, admitting no power or privilege on the one side, or disability on the other. Consensus among feminist and liberal writers on the negative implications of male dominance is evident [2]. Patriarchy is viewed in some quarters as an institutional mechanism that serves to limit women's economic autonomy relative to men's. The result is that women unwittingly depend almost entirely on men, which has implication for the involvement of the former in family decisions, including reproductive health, even when they are directly affected.

Gender

Studies have shown that socialization into sexuality and gender roles begins early in the family and community and are reinforced through the interplay of familial, social, economic and cultural forces, which are subsumed in patriarchy [6]. Similarly, Isiugo-Abanihe [6] maintained that cultural dictates shapes behaviours; one's environment affects her reproductive attitudes, perceptions and motivations. To corroborate this assertion, it was observed that the use and non-use of health services are determined by one's socio-cultural environment, which, in most cases,

is shaped by its patriarchal structure [7]. A scholar has also noted that many culture bound syndromes are effectively managed through an informed knowledge of their cultural contexts and the background of patients [8].

Some socio-cultural factors, which not only prevent women from getting out of their homes to utilize maternal health facilities, even in emergencies, but also prohibit them from eating certain foods, have been identified [9]. For instance, in parts of Nigeria, cultural taboos discourage pregnant women from eating certain fruits, vegetables, rice and other high-calorie foods that ordinarily reduce susceptibility to diseases and malnourishment during the period [10]. Most of these restrictions are given in order to sustain the myth surrounding a particular tradition or to emphasize the sacredness of a custom conceived as inviolable.

Another factor affecting maternal health seeking behaviour in Africa is associated with gender equality. Researchers studying women in Northern Nigeria also found a gender measure in decision making for a child being fully vaccinated [11]. The curvilinear relationship between maternal conjugal decision-making power and child immunization is curious. Indeed, it is not clear why the positive relationship between conjugal power and child immunization is reversed at higher levels of conjugal power. Nonetheless, a few studies have found a similar relationship in sub-Saharan Africa [12]. One could possibly infer that in a society where gender norms absolutely restrict women's participation in household decision making power process, women with high conjugal power tend to be those who live separately from their husbands and have limited access to substitute caregivers with whom to share the responsibility of household chores and childrearing thereby making limited time available for them to take their children for immunization [11].

Itwas found that women in Zimbabwe who did not have a say in household decisions were more likely to have low Body Mass Index (BMI) than women who did have some say [13]. Researchers studying women in Nigeria have recently found that gender equality is significantly associated with whether a woman has a facility for delivery [14] and whether her child is fully immunized [15].

In considering attitude and practice of males towards antenatal care, Nuraini and Parker [16] submitted that antenatal care is a key strategy for reducing maternal mortality and a crucial determinant for safe delivery. ANC is the attention, education, supervision and treatment given to the pregnant mother from the time confirmed until the beginning of labour in order to ensure safe pregnancy, labour and puerperium. Male involvement functions should seek to address men's own health needs and concerns as well as the needs of their female partners. In their view, if adequately supported, many men will rise to curb traditional practices that might endanger their partner's health.

It was also stated [17] that, lack of knowledge by male partners of complications associated with delivery, cultural beliefs, high fees charged for deliveries at health facilities and un-cooperative health workers are major contributing factors to low male partner involvement in child birth

activities, hence, improving the levels of education and income of male partners, addressing the cultural beliefs and practices, improving health care provider-client relationship and sensitizing men on complications associated with pregnancy and child birth can contribute significantly in enhancing male partner involvement in promoting deliveries. 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 [18].

Males are generally excluded from participating in routine care because the medical system does not accommodate them and the community considers maternal care as exclusively preserve of women. Males tend to be decision makers within the family and often govern behaviour regarding the availability of nutritious food, women's workload and the allocation of money, transport and time for women to attend health services, yet, men are often unable to make informed choices because they have not been included in maternal and child health services. Literature revealed that male involvement should not be seen as limited to men's participation in clinical services [19]. In practice, male involvement includes the wide variety of actions that men take to support and protect the health of their wives and children. Men can positively influence maternal and child health issues in a variety of ways and have a right to the information they need to make decisions to protect their own health and that of the family.

Male involvement includes men making informed decisions with their partners or seeking and sharing information about appropriate health behaviour and care during pregnancy, child birth and postpartum. Men can encourage and support antenatal care attendance, ensure good nutrition and reduce workload during pregnancy, assist with birth preparations and provide emotional support for their wives at home.

According to Jose [20], Nigeria has one of the worst maternal health indicators across the globe. In most African countries, maternal health issues which include family planning, pregnancy and childbirth have long been regarded exclusively women's affairs [21]. It has been noted that men's involvement in maternal health is an encouraging strategy for promoting maternal health [22]. Mullay, Hindin& Becker [21] 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. Stycosalso observed that men's behaviour and involvement in the maternity care of their pregnant partners can significantly affect the health outcomes of the women and babies [18].

Secka [23] opined that, globally it is estimated that nearly 500,000 women die annually from causes related to pregnancy and child birth and 99 percent of these deaths occur in developing countries. It is sometimes seen as a sign of weakness or bewitchment in some cultures when a man follows his wife to clinic. Many men believe that their participation in Prevention of Mother to Child Transmission (PMTCT) would signal weakness and lack of masculinity and power to other men [24].

In 2002, a longitudinal study was conducted in the United States with a sample size of 5404 women and their partner which explored the effect of father involvement during pregnancy on receipt of prenatal care and maternal smoking. The findings of the study indicated that women whose partners were involved in their pregnancy care were 1.5 times likely to attend prenatal care in the first trimester and smokers reduced smoking by 36 percent as opposed to those whose partners were not involved in their pregnancy care [25].

Literature on socio-cultural factors of gender roles in women's healthcare utilization revealed that 62 percent of births in Nigeria occur at home, 36 percent of women received no antenatal care, only 39 percent of births were delivered by a skilled provider and 56 percent of women did not receive any post-natal care within 41 days of delivery [26]. Several factors lead to such horrendous statistics and dismal performance on maternal health status indicators such as economic, environment, health, social and culture [27]. The last two, socio-cultural factors are the less studied. Culture reinforces the gender roles and life style of husband and wives, making it difficult for the females to exercise her rights including reproductive rights and behaviours. Social and cultural norms concerning gender roles powerfully shape women's autonomy [28].

On one hand, Jejeebhoy [28] opined that in many homes in South Western Nigeria, husband's permission is required before a wife could seek healthcare and it depends on whether the husband sees the ill health as strong enough to warrant hospital treatment. A scholar defined gender ideology based on data from a case study of a rural Ekiti Yoruba village in South Western Nigeria as beliefs about the nature of women and men and their appropriate behaviours in society on reproductive decision making [29]. Men are believed to be head of households, have authority over family members and decide on what happens in the household ranging from social, economic, cultural and health related issues. Renne [30] opined that men have superior knowledge over the women. Adding a voice to this subject, Omideyi, [31]observed that many women are denied their rights and subjected to some cultural practices that greatly endanger their health in Nigeria. On the other hand, [32]women are deprived of decision making positions both in the private realm of the family and the public sector and others make decisions that directly or indirectly affect their lives on a daily basis. This scenario makes it difficult for women to access health care even in emergency situations.

Few studies have examined explicitly the relationship between socio-cultural factors and maternal utilization of health services especially as it relates to gender roles in sub-Saharan Africa including Nigeria. For instance, Longwe, [33]noted that the trend in developing countries is much worse, as studies from various countries of sub-Saharan Africa indicate that maternal mortality has not only continued to be high, but is indeed increasing after the launch of the Safe Motherhood Initiative (SMI) in Kenya in 1987. Similarly in Nigeria, not only the Federal Ministry of Health set Year 2006 as the target year that maternal mortality would have been reduced by half, but to the contrary the situation of maternal health in Nigeria was even much worse than in previous years [34].

Education of women has a powerful role in health utilization outcomes. It acts as catalyst for changes and a transformer of high female autonomy. Parpart, Connelly &Barriteu [35] observe that the hallmark of Kerela's success in health care use by female is to better female education and autonomy. Others have equally confirmed that education of women as an important determinant of health and a valuable public good in its own right [36]. Scholars have suggested that culture and social systems were more important determinants of health than health systems itself [37]. Also, researchers have added to the literature on the distal determinants of health such as political, social, macro-economic and cultural factors [38, 39, 40, 41]. Similarly, Subramanian, [41] observe in their own dimensions of women autonomy and maternal health utilization in a North Indian city ascertain the influence of women's autonomy on the use of care during pregnancy and child birth in the study area. They further assert that the influence of women's autonomy on the use of health care appears to be as important as other known determinants such as education.

The cultural perspective on the use of maternal health services suggests that medical need is determined not only by the presence of physical disease but also by cultural perception of illness [43], influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of individual women [44] and decisions about maternal care are often made by husbands or other family members [45]. It was found out that a husband's approval has a greater effect on pre-natal care utilization than whether a wife wanted the pregnancy or a wife's level of education [46]. Although, women in higher socio-economic groups tend to exhibit patterns of more frequent use of maternal health services than women in the lower socio-economic groups, factors such as education appear to be important mediators [43, 47, 48].

Cultural tenets appear to structure women's education thereby de-accelerate female autonomy and their capacity to decide or partake in the decision making process of the family or household. In a study investigated among women from four local governments in Benue State, Nigeria, Biratu & Lindstrom [49] showed that education and domicile play significant roles in the health-seeking behaviour of pregnant women.

Addai, [50]equally confirmed that women's and husband's education have a strong relationship with maternal health care utilization while women's autonomy had a weak relationship with various form of ante-natal and delivery care usage in his study. Leslie & Gupta, [51] added that cultural practice of the Hausa people plays a major role in determining women's choice of place of child delivery in addition to poor hospital services and nature of attendants which may violate women's privacy. In consonance with the above finding, Kistiana, [52] opined that ethnicity, religion and traditional belief are often consistent markers of cultural background and are thought to influence beliefs, norms and values in relation to child birth and service use by women. Certain ethnic or religious groups may be discriminated against by staff making them less likely to use health care services. It was further argued that socio-cultural beliefs and the need for immediate and specialized services have hampered women's ability to access services in many low and middle income countries including Nigeria.

The game of effective reduction of maternal mortality should not be left alone with the provision of facility but re-engineered towards behavioural change. In a cross-sectional study in Nigeria, [53], it was found that efforts were required to improve men's attitudes and knowledge in order to make them appreciate and be active participants in the fight to reduce maternal mortality, which begins with utilization of the available health care facility. In an exploratory study which focused on socio- cultural factors affecting pregnancy outcome among the Ogu speaking people of Badagry area of Lagos State, Nigeria, scholars [54]found that the culture of the people of Ogu Community was very dominant in shaping their reproductive behaviour.

In a study among childbearing women in Ibadan North Local Government Area of Oyo State Nigeria, [55] itreveals that husband's decision or preference of ANC and privacy constituted the prominent factors that influenced the choice of ANC as well as place of delivery. In another study among pregnant women in Ife Central Local Government Area, Osun State, Nigeria, a group of researcher [56]with a stratified sample of 102 pregnant women revealed among others that lack of knowledge about the existing services in ANC and husband's acceptance of the services rendered as the major factors influencing its utilization. Using community- based research, it wasfound that most pregnant women had little or no contact with the health care system for reasons of custom, lack of perceived need, distance, lack of transportation, lack of permission, cost and/or unwillingness to see a male doctor [57].

Studies revealed that factors like husband's approval, money for treatment, and personal cultural preferences still had negative effects on the maternal health seeking behaviour in the Benin Republic [58]. A secondary data based study from the Zimbabwe Demographic and Health Survey (ZDHS) between 2005 and 2006, found age, education, wealth, polygamy and religious affiliation among other variables [59]. Commonly held beliefs and norms that could be religious or cultural, shape the way individuals perceive their own health and the health services available. Religious and cultural beliefs have been found to be sources of exclusion from maternal healthcare utilization in India and Africa [60]. Although most studies have ignored polygamy, it is a customary practice that is associated with traditionalists.

Suffice to say that women in polygamy were less likely to report for delivery at a health institution. Maternal healthcare utilization is constrained by women's lack of decision making power, the low value placed on women's health and the negative or judgmental attitudes of family members. Women with more self-sufficiency in decision making, which is determined by society and culture, have also been found to be more likely to use maternal healthcare [60].

Education has been found to be a source of exclusion in studies conducted in India and different countries in Africa. A duo of scholar [61] found education linearly increasing with utilization of maternal healthcare in Ethiopia. Uneducated women less likely to use maternal healthcare, but found no differences in utilization among the educated [62]. It is discovered that education assists women placing autonomy resulting in women developing greater confidence and capabilities to make decisions regarding their own health [50]. The significant impact of education on delivery

at health institutions is evidence that educated women have better knowledge and information on modern medical treatment [50]. The link from education to higher utilization of health services extends to better health outcomes like lower child and maternal mortality [63]. Poor use of antenatal care among Nigerian women has been a great concern to public health because of its life threatening and other negative consequences to the health of mothers and the child [64].

A study looked into the significant determinants of antenatal care service use in Nigeria, specifically focusing on Ibadan. Four hundred women in two randomly selected local government areas of Ibadan were surveyed to achieve the study objective of investigating the factors that are associated with antenatal care use in Ibadan [49]. The study revealed a significant difference in residence, religion and age in relationship with antenatal care use in Ibadan.

White, Dynes, Rubardt, Sissoko & Stephenson [65] studied the factors that are significantly associated with the usage of antenatal care services in rural northern Nigeria. The study was explicitly done in a village setting of Kumbotso in Kano, Nigeria. The study used data from 200 women of childbearing age in the village community to assess factors that significantly determine antenatal care use in the village. The study found that women education and the education of the husband were positively associated with antenatal care use among rural women. The higher the educational status attained by both spouses, the higher the use of antenatal care among women. In a community-based survey of maternal health conducted in Yirgalem town, South West Ethiopia, a husband's approval has a greater effect on prenatal care utilization than whether a wife wanted the pregnancy or a wife's level of education [66].

Cultural factors have also been noted to affect the utilization of maternity care services in Africa [67]. In consonance with the above assertion, Bloom, Wypij and Das Gupta, [45]corroborates that in many parts of Africa, women's decision making power is extremely limited, particularly in matters of reproduction and sexuality.

A study on cultural background and socio-economic influence on women coping with postpartum depression note that pregnancy and childbirth might be similar worldwide, but how Postpartum Depression (PPD) is conceptualized and experienced by women of diverse cultures might be quite different [68, 69, 70, 71]. How women define PPD and their attitudes toward it will be a strong influence in how they utilize and access social support networks and mental health care services. Moreover, lack of knowledge about and understanding of PPD can limit help-seeking behaviour. Culturally determined barriers include fear of stigma and lack of validation of depressive symptoms within the family and within the ethnic community. New mothers suffering from postpartum depression might not have any knowledge of PPD. They might be reluctant to reveal feelings to family and friends and to seek help for their challenges [72].

In some cultures it might be perceived that it is inappropriate to seek external help for depressive symptoms. Medical assistance might seem inappropriate if PPD is not understood to be a medical problem [73,74,75,69]. Rodrigues et al. [74] found that Asian Indian mothers suffering from PPD

perceived their symptoms to be natural sequelae of childbirth and were therefore unlikely to access health care services. It has been reported that in Asian Indian communities, maternal depression often goes unrecognized, leaving the mother isolated within her own family [76, 77].

Barclay & Kent [78] observed that the difficulties of new immigrant mothers are exacerbated if they come from cultures where women are held in high esteem and valued and supported during the postnatal period. Cultural beliefs can serve in positive and protective ways when the mother and family participate in traditional customs and rituals that bolster the mother's network of support. Assigning value and respect to the mother's role can improve the mother's overall postpartum health. When cultural expectations and beliefs are not met, the woman can be susceptible to depression. Oates et al. [68] found that recent immigrant mothers might find themselves bereft of the emotional and practical social support they would normally expect in their home country.

Conclusion

This paper made a review of the related literature directly relevant to gender and patriarchy n relation to maternal health seeking behaviour. Following from the review, it can be argued that most of the findings from previous studies solely depend on data generated using single method of social investigation and limited theoretical background whereas studies involving maternal health deserves an exploration the strength in mixed method and theoretical triangulation, this calls for further research that will stimulate a holistic framework for understanding maternal health issues in sub-Saharan Africa. In addition, while many researchers have addressed maternal morbidity and mortality issues in sub-Saharan Africa, studies related to factors affecting maternal health seeking behaviour in the region on the other hand are not extensive. Summarily, this reviewer have interrogated the secondary literature and examined how other authors have dealt with the issue relating to maternal health and specifically its interplay with gender and patriarchyand in so doing revealed gaps in the current scholarship that future researchers will address.

References

1. Bwakali D. J. (2001) Gender Inequality in Africa: Contemporary Review, http://findarticles. com/p/articl.
2. Nwokocha, E. E. (2004). "Socio-cultural factors affecting pregnancy outcomes among the Ibani of Rivers State". A Ph.D Thesis submitted to University of Ibadan.
3. Barrett M. E. Behavioural Research Programme, Texas, A & M.
4. Gray J. A. (1982). Preci of the Neuropsychology of anxiety: An enquiry into the functions of the septo. Behavioural and Brain Sciences 5 (3):469-44.
5. Ottong (1993) Principle of Matriliny. As cited by EE Nwokocha in Male-child syndrome, University of Ibadan.

6. Isiugo-Abanihe, U. C. (2003). Male role and responsibility in fertility and reproductive health in Nigeria, Lagos: Ababa Press.
7. oke, E. A. (1996). The Emergence of Medical Sociology". In E.AOke and B. E. Owumi eds. Readings in Medical Sociology. Ibadan: Resource Development and Management Services., pp. 1-14
8. Erinosho, O.A. (1998). Health Sociology, Ibadan: Sam Bookman Educational Communication.
9. Jafrey S. N. and Korejo R. (1993) Mothers brought dead: an enquiry into causes of delay. Social Science and Medicine 36: 371-2.
10. Mbagua (1997). The African Family and the status of Women's health in A. Adepoju ed. The Family, Population and Development in Africa. London: zed Books,. pp. 139-157.
11. Babalola, S. (2009). Determinants of the uptake of the full dose of Diphtheria- Pertussis-Tetanus vaccines (DPT3) in Northern Nigeria: A multilevel analysis. Maternal and Child Health Journal, *13*, 550-558. doi:10.1007/s10995-008-0386- 5.
12. Smith, Ramakrishnan, Ndiaye, Haddad & Martorell, 2003.
13. Hindin, M. J. (2000). Women's power and anthropometric status in Zimbabwe. Journal of Social Science and Medicine, *51*, 1517-1528. doi:10.1016/s0277-9536(00)00051-4
14. Singh, K., Bloom, S., Haney, E., Olorunsaiye, C., & Brodish, P. (2012). Gender factors and facility delivery: Nigeria and MDG5. African Journal of Reproductive Health, 16, 122-128.
15. Singh, K., Haney, E., & Olorunsaiye, C. (2013). Maternal autonomy and attitudes towards gender norms: Associations with childhood immunizations in Nigeria. Maternal and Child Health Journal, 17, 837-841. doi:10.1007/s10995-012-1060-5.
16. Nuraini, E. & Parker, E. (2005). ''Improving knowledge of antenatal care (ANC) among pregnant women: a Field trial in Central Java, Indonesia'', Asia Pacific Journal of Public Health, 17(1): 3-8.
17. Nanjala, M. &Wamalwa, D. (2012). Determinants of male partner involvement in promoting deliveries by skilled attendants in Busia'', Kenya. Global Journal of Health Science, 4(2): 60-67. [Online] Available: www.ccsenet.org/gjhs (April 21st, 2014)
18. Stycos, J. M. (1996). Men, couples and family planning: A retrospective look'', Working paper No. 96- 12. Cornell University Population and Development Program, Ithaca, New York.
19. Singh, S., Darroh, J., Vlassoff, M., & Nadeau, J. (2006). The benefits of maternal health care. Sexual and Reproductive Health Care'', New York.
20. Jose, L. A. (2010, April 21). Most maternal deaths in sub-Saharan Africa could be avoided'', Science Daily. Retrieved http://www.sciencedaily.com/releases/2010/02/100218092852.htm.
21. Mullay, B. C., Hindin, M. J., & Becker, S. (2005). Can women's autonomy impede male involvement in pregnancy health in Kathmandu, Nepal?'', Journal of Social Science and Medicine. 61(9):1993-2006.
22. Cohen, S. I., & Burger, M. (2000). Partnering: A new approach to sexual and reproductive health'', Technical Paper No. 3. United Nation Population Fund.
23. Secka [2010].

24. World Health Organization. (2012, April 21). Male involvement in the preparation of mother-to-child transmission.Retrieved from www.who.int/reproductivehealth.
25. Martin, M. T., Mcnamara, M. J., Millot, A. S., Halleh, T., & Hair, E. C. (2007). The Effect of father involvement during pregnancy and receipt of prenatal care and maternal smoking'', Maternal and Child Journal 11, 595-602.
26. Nigeria Demographic and Health Survey (NDHS) (2000) Nigeria: DHS, 1999-Final Report. Measure DHS, Calverton.
27. Jenna, K., Muller, B., & Quiros, A. (2009). Women, men, and the changing role of gender in immigration. Student Research Series, 3, 1-14.
28. Jejeebhoy, S. J. (2002). Convergence and divergence in spouses' perspectives on women's autonomy in rural India.Studies in Family Planning, 33, 299-308. http://dx.doi.org/ 10.1111/ j.1728-4465.2002.00299.x.
29. Adewuyi, A. (1999). Understanding male involvement in maternal emergencies. OkeGada, Ede.
30. Renne, E. P. (1993). Gender ideology and fertility strategies in an Ekiti Yoruba Village.Studies in Family Planning, 24, 343-353. http://dx.doi.org/10.2307/293924.
31. Omideyi, A. (1987). Status, cultural beliefs and fertility behavior among Yoruba women. In: Ebigbola, J. & Van de Walle, E., Eds., The cultural roots of African fertility Regimes: Proceedings of the Ife Conferences, ObafemiAwolowo University, Ile-Ife and University of Pennsylavania, Philadelphia, 151-165.
32. Mama, A. (1996) Women's studies and studies of women in Africa during the 1990s Dakar, CODESRIA: Working Paper Series 5/96.
33. Longwe, S. H. (2002). Assessment of the gender orientation of NEPAD. In: Nyong'o, P.A., Ed., New Partnership for Africa's Development NEPAD: A New Path, Heinrich Boll Foundation, Nairobi, 252-274.
34. Shah, I. H. & Say, L. (2007). Maternal mortality and maternity care from 1990-2005: Uneven but important gains. Reproductive Health Matters, 15, 17-27. http://dx.doi.org/10.1016/ S0968-8080(07)30339-X.
35. Parpart, J., Connelly, M., &Barriteu, V. (2000). Theoretical perspectives on gender and development. International Development Research Centre, Ottawa.
36. Obermeyer, C. M. (1993). Culture, maternal health care, and women's status: A comparison of Morocco and Tunisia. Studies in Family Planning, 24, 354-365. http://dx.doi.org/10.2307/ 2939245.
37. Wall, L.L. (1998). Dead mothers and injured wives: The social context of maternal morbidity and mortality among the Hausa of Northern Nigeria. Studies in Family Planning, 29, 341-359. http://dx.doi.org/10.2307/172248.
38. Soares, R.R. (2005) Mortality Reductions, Educational Attainment, and Fertility Choice. *American Economic Review*, 95, 580-601. http://dx.doi.org/10.1257/0002828054201486
39. Preston S. H. [1991].
40. Mosley, W. H. (1984). Child survival: Research and policy. Population and Development Review, 10, 3-23. http://dx.doi.org/10.2307/2807953.

41. Preston, S. H., & Haines, M. R. (1991). Fatal years: Child mortality in late nineteenth century America. Princeton University Press, Princeton. http://dx.doi.org/10.1515/9781400861897
42. Bell and Kawachi 2002
43. Marmot, M. (2005). Social determinants of health inequalities.The Lancet, 365, 1099- 1104. http://dx.doi.org/10.1016/S0140-6736(05)74234-3
44. Lieberman, E. S. (2007). Ethnic politics, risk, and policy-making: A cross-national statistical analysis of government responses to HIV/AIDS. Comparative Political Studies, 40, 1407-1432. http://dx.doi.org/10.1177/0010414007306862.
45. Bloom, S. S., Wypij, D., & Das Gupta, M. (2001). Dimensions of women's autonomy and the influence on maternal health care utilization in a North Indian City.Demography, 38, 67-78. http://dx.doi.org/10.1353/dem.2001.0001.
46. Addai, I. (2000). Determinants of use of maternal-child health services in rural Ghana. Journal of Biosocial Science, 32, 1-15.
47. Adetunji, J.A. (1991). Response of parents to five killer diseases among children in a Yoruba community, Nigeria. Social Science and Medicine, 32, 1379-1387. http://dx.doi.org/10.1016/0277-9536(91)90198-L.
48. World Health Organization (1998). Improved access to maternal health service.WHO. Geneva.
49. Biratu, B. T., & Lindstrom, D. P. (2006). The influence of husbands' approval on women's use of prenatal care: Results from Yirgalem and Jimma Towns, South West Ethiopia. Ethiopian Journal of Health Development, 20, 84-92.
50. Addai, I. (1998) Demographic and socio-cultural factors influencing use of maternal health services in Ghana. African Journal of Reproductive Health, 2, 73-80.
51. Leslie, J., & Gupta, G. R. (1989). Utilization of formal services for maternal nutrition and health care.International Center for Research on Women, Washington DC.
52. Kistiana, S. (2009) Socio-economic and demographic determinants of maternal health care utilization in Indonesia. Unpublished Master's Thesis, The Flinders University of South Australia, Adelaide.
53. Gabrysch, S., & Campbell, O.M.R. (2009). Still too far to walk: Literature review of the determinants of delivery service use. Journal of BioMed Council on Pregnancy and Childbirth, 9, 34. http://dx.doi.org/10.1186/1471-2393-9-34
54. Lawoyin, T. O., Lawoyin, O. C. &Adewole, D. A. (2007). Men's perception of maternal mortality in Nigeria.Journal of Public Health Policy, 28, 299-318. http://dx.doi.org/10.1057/palgrave.jphp.3200143.
55. Ajiboye, O. E., & Adebayo, K. A. (2012). Socio-cultural factors affecting pregnancy outcome among the Ogu speaking people of Badagry area of Lagos State, Nigeria. International Journal of Humanities & Social Science, 2, 133.
56. Ewa, E. E., Lasisi, C. J., Maduka, S.O., Ita, A.E., Ibor, U. W. &Anjorin, O. A. (2012). Perceived factors influencing the choice of antenatal care and delivery centres among childbearing women in Ibadan North South-Western, Nigeria.Ethiopian Journal of Environmental Studies and Management, 5, 373-383. http://dx.doi.org/10.4314/ejesm.v5i4.6

57. Onasoga, O.A., Afolayan, J.A. & Oladimeij, B.D. (2012). Factors Influencing Utilization of Antenatal Care Services among Pregnant Women in Ife Central Lga, Osun State, Nigeria. Advances in Applied Science Research, 3, 1309-1315.
58. Owumi, B., & Raji, S. O. (2013). Socio-cultural determinants of maternal health care seeking behavior in Seme side of Benin Republic. African Journal of Social Sciences, 3, 145-158.
59. Muchabaiwa, L., Mazambani, D., Chigusiwa, L., Bindu, S.&Mudavanhu, V. (2012). Determinants of maternal healthcare utilization in Zimbabwe.International Journal of Economic Sciences and Applied Research, 5, 145-162.
60. Stephenson, Baschieri, Clements, Hennink, &Madise, 2006
61. Mekonnen, Y. &Mekonnen, A. (2002). Utilization of maternal health care services in Ethiopia.ORC Marco, Maryland.
62. Navaneetham, K. &Dharmalingam, A.(2000). Utilization of maternal healthcare services in South India. Faculty seminar at the Centre for Development Studies, Thiruvananthapuram, 31 March 2000, 1-40.
63. Boyle, M. H., Racine, Y., Georgiades, K., Snelling, D., Hong, S., Omariba, W., Hurley, P., & Rao-Melacini, P. (2006). The influence of economic development level, household wealth and maternal education on child health in the developing world. Journal of Social Science and Medicine, 63, 2242-2254. http://dx.doi.org/10.1016/j.socscimed.2006.04.034
64. McCarthy, J. & Maine, D. (1992). A framework for analyzing the determinants of maternal mortality.Studies in Family Planning, 23, 23-33. http://dx.doi.org/10.2307/1966825
65. White, D., Dynes, M., Rubardt, M., Sissoko, K., & Stephenson, R. (2013). The influence of intra-familial power on maternal health care in Mali: Perspectives of women, men and mothers-in-law. International Perspectives on Sexualand Reproductive Health, 39, 58-68.
66. Fayomi, O. O., & Igbokwe, N. (2009). Women's reproductive health-A question of human rights in the context of HIV/AIDS in Nigeria. *MP*: A Feminist Journal (Gender and Race), 2, 30.
67. World Health Organization. (1996). Final report of the seminar on the use of medicinal plants in health care. WHO WPRO Publication, Tokyo
68. Oates, M. R., Cox, J. L., & Neema, S. (2004). Post-natal depression across countries and cultures: a qualitative study. British Journal of Psychiatry; 184(suppl.46):10S-6S.
69. Teng, L., Robertson, Blackmore, E., & Stewart, D. (2007). Healthcare workers perceptions of barriers to care by immigrant women with postpartum depression: an exploratory qualitative study. Arch Womens Mental Health. 2007; 10: 93-101.
70. Morrow M, Smith J. E., Lai Y., & Jaswal S. (2008). Shifting landscapes: immigrant women and postpartum depression. Health Care Women Int.; 29: 593-617.
71. Bina, R. (2008). The impact of cultural factors upon postpartum depression: a literature review. Health Care Women Int. 2008; 29: 568-92.
72. Dennis, C. L, & Chung-Lee L. (2006). Postpartum depression help-seeking barriers and maternal treatment preference: a qualitative systematic review. Birth; 33:323-31.
73. Holopainen D. (2002).The experience of seeking help for postnatal depression. Australian Journal of Advance Nursing; 19(3):39-44.

74. Rodrigues, Petal, Jaswell & Dasonza [2003]
75. Ugarriza, D. N. (2004). Group therapy and its barriers for women suffering from postpartum depression. Arch Psychiatric Nursing. 2004; 18: 39-48.
76. Hearn G, Iliff A, Jones I, Kirby A, Ormiston P, Parr P, et al. (1998). Postnatal depression in the community. British Journal of General Practices. 1998; 48: 1064-6.
77. Goyal, D., Gay, C., & Lee K. A. (2010). How much does low socioeconomic status increase the risk of prenatal and postpartum depressive symptoms in first-time mothers? Women's Health Issues. 2010; 20:96-104.
78. Barclay, L. & Kent, D. (1998) Recent Immigration and the misery of motherhood: A discussion of pertinent issues. April 1998. Midwifery 14(1):4-9, PubMed. DOI: 10.1016/ s0266-6138(98)90108-5.

