

SOCIO-CULTURAL FACTORS AND MATERNAL MORTALITY IN YAURI EMIRATE, KEBBI STATE, NIGERIA

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Abstract

Globally, at least one woman dies every minute from complications related to pregnancy or child birth. This research is aimed at examining the socio-cultural factors affecting maternal mortality in Yauri Emirate, Kebbi State, Nigeria. The intersectionality theory was used in this research. The research adopted a descriptive survey design. Also, 338 respondents constituted the sample of this study. Out of which, 329 respondents were administered structured questionnaires and 9 participants were interviewed. The data obtained from the questionnaires were analyzed using simple percentage and multiple regression while the data obtained from the interviews were analyzed using matrix table. The study found that socio-cultural factors significantly affect the rate of maternal mortality in Yauri Emirate because cultural practices like early marriage traditional practices and taboo significantly affect the rate of maternal mortality. The study therefore recommended that traditional rulers should encourage the proper prescription of herbal medications for women during pregnancy since some of the women prefer herbal medication, but used it without proper guide. More importantly, to curb the growing rate of maternal mortality in Yauri Emirate, pregnant women should speak out when they have issues during pregnancy or even after delivery. Keywords: Maternal, Mortality, Socio-cultural, Yauri Emirate, Nigeria

Keyword: Socio-Cultural, Maternal Mortality, Yauri

Introduction

Maternal mortality is one of the greatest health challenges today. According to World Health Organization (WHO) many women dies from the complications related to pregnancy or child birth. (United Nations Millennium Summit, 2000; WHO 2003; WHO, 2005). United Nation Millennium Summit (2000) reported that the number one killer of women in developing countries is not disease whose cure eludes the world or condition which the world lacks resources to treat rather it is pregnancy and childbirth. World Health Organization (2005) noted that in addition to every woman who dies in child birth, around 20 or more others suffer injury, infection or disease (United Nations Millennium Summit, 2000; WHO 2003; WHO, 2005).

Amala et al. (2003) have observed that, of 515,000 maternal deaths that occur every year, 90% take place in developing countries. Women in developing countries have 1 in 48 chances of dying from pregnancy related causes, while the ratio in developed countries is 1 in 1,800 (Amala et al. 2003). In addition to this, a reasonable number of women in Africa still suffer from diseases and

other related problems. Amala et al. (2003) went further to argue that, of all the human development indicators, the greatest discrepancy between developed and developing countries is maternal and child health. Nigeria as one of the developing country was only able to achieve 23.6% reduction in the rate of maternal mortality which was three times less than the target contained in the Millennium Development Goal (MDG) goal 5 by United Nations which targeted 75% reduction in the rate of maternal mortality by 2020. Also, the rate of maternal mortality has remained high in the rural areas compared to urban areas in Northern Nigeria. In the same study, the rate of maternal mortality is higher in Northern Nigeria compared to Southern Nigeria because of high rate of poverty, religious and cultural factors (Meh, Thind, Ryan and Terry, 2019).

Muoghalu (2010) explained that cultural factors such as taboos and gender relations have contributed to the prevalence of maternal mortality in Nigeria. However, even though WHO (2009) reports that life expectancy was higher for women than men in most countries, a significant number of health situation and socio-cultural factors combine to create lower quality of life for women in developing countries. Women from Yauri emirate are typical of rural Nigerian women as well as women in other rural populations of developing countries. In Yauri for instance, issues relating to access and utilization of health care services by pregnant women are largely dependent on many socio cultural factors. More also, in this Emirate many women have lost their lives due to pregnancy complications which would have been easily managed if they have had opportunity to qualitative health care services. To them several socio cultural factors such as gender relations, taboo, purda and other traditional practices has contributed significantly to the high rate of maternal mortality. It is against this background that this research examines the socio-cultural factors leading to maternal mortality in Yauri Emirate, Kebbi state, Nigeria.

Literature Review

Cole and Packer (2011) viewed culture as a universal human experience with a clear picture of psychological and protective factors of pregnancy in cultural contexts. It is documented that previous research focused on biomedical causes and treatments for maternal mortality and largely neglected realities in countries where maternal mortality remained high, due to culture and traditional health practices which dictate what should happen during childbirth (Geller, Goudar and Adams, 2008). The indigenous beliefs and practices that shape the cultural traits are passed from one generation to the next. Shaikh and Hatcher (2005) were of the notion that cultural aspects of pregnancy are often neglected, whereas, these practices are deeply rooted and embedded in the societies. Cultural practices become part of the people's lifestyle and it becomes difficult to change their beliefs and practices. It can be concluded that belief systems could play a major role in health-care-seeking behavior of the family members.

Maputle, Khoza and Lebese (2015) found that cultural stereotype influences decisions, for example, not to tell other people about what is happening with the pregnancy or the gestational age because the pregnancy will be aborted. The cultural attitudes to health care in general, and uterine bleeding in particular, influenced the provision of care to affected women. For example, it has been culturally noted that a regular, heavy, red menstrual bleeding is perceived as providing a "healthy clean-out of the womb," and this could contribute to substantially delaying presentation for professional care (Malcolm, Oskari, Rohana, Jaydeep and Fraser, 2011). Culture also determined gender norms that deny women the ability to make their own decisions or seek care without their husbands permission. (Ujah et al, 2005). Cultural stigma in the communities, for example husbands in the community who insist on their women doing difficult household

chores when they are pregnant, can play a serious impact on maternal mortality due to haemorrhage from placenta abruption in rural communities.

Theoretical Framework

This study adopted the intersectionality theory. The major proponent of Intersectionality theory is Patricia Collins. Intersectionality theory is one of the varieties offeminist theory. The major concern of the feminist theory is the situation and experiences of women in society. It treats women as central subjects in the investigative process, that is seeing the world from the distinctive vantage point of women in the social world (Ritzer, 2000). Intersectionality theory accept the fact that the basis of contemporary society is the exploitation and oppression of women by men but argues that women experience oppression in varying configurations and in varying degrees of intensity. According to this theory while all women potentially experience oppression on the basis of gender, women are nevertheless differentially oppressed by the varied intersections of other arrangements of social inequality (Ritzer, 2000:471). Women are faced with a lot of oppression and exploitation in the health sector. WHO (2009) noted that though women look after the health needs of others, whether in the home or in the community, their own health needs are often neglected. Maigua (2009) maintained that women are being denied access to health care at key moments of their lives. Both the neglect of women's health needs and denial of access to health care are all rooted in historical oppression of women in our society. However, in line with the intersectionality of oppression which this theory explains, WHO (2002) observed that the greatest burden of health risk is very often borne by the disadvantaged in our societies. In the other words while women generally experience poor health status probably because of their biological conditions or other socio-cultural factors affecting them, the vast majority of threat to health is more commonly found among poor people; in people with little or no formal education and those with lowly occupation. The point here is that, while women generally may have low health status, rural women because of inaccessible, unavailable health care services, lack of education, poverty, etc. are more likely to have poorer health status.

One of the major shortcomings of this theory is that it has laid too much emphasis on gender inequality and women oppression. While ignoring other wider social factors like social interaction and socio economic status. However, This theory is chosen because it traces the consequences of class, race, gender, affectional preference, and global location for lived experience, group standpoint and relations among women (Ritzer, 2000). It also explains and identifies those socio cultural factors affecting utilization of health care services by pregnant women which eventually lead to their death in Yauri Emirate.

Methodology

This study adopts descriptive research design. This design was chosen because it often gives the opportunity to integrate qualitative and quantitative method of data collection. The research was cross sectional and conducted in Yauri Emirate. It was conducted in Yauri emirate, due to overwhelming record of maternal mortality in the area. Yauri Emirate is one of the Emirates in Kebbi state. It has three Local governments under it which include Yauri, Shanga and Ngaski. The total sample size of this study is 329. This sample size consists of 384 respondents and 9 participants. The sample size of the respondents who were used for the quantitative study was determined using Z score formula. The sample size was divided among the three Local governments (Yauri, Shanga and Ngaski). 128 respondents were selected from each of the three local governments using snowballing method. Furthermore, the 9 participants who were selected for this study included 1 husband, 1 parent, 1 religious leaders, 3traditional leaders, 3medical practitioners. They were purposively selected for this study because they have vital information

about the subject matter and they provided their information from various perspectives. The researcher employed primary data collection instruments which includes a questionnaire and key informant interview guide; schedule on the selected respondents. The data presentation and hypotheses testing were done with the aid of the statistical package for social sciences (SPSS version 24). While the qualitative data was analyzed using content analysis.

Results

Socio-Demographic Characteristics of Respondents

Table 1: Age, Marital Status and Numbers of Children of the Respondents

Age	Frequency	Percentage
18-27	96	29.2
28-37	131	39.8
38 and 47	67	20.4
48 and above	35	10.6
Total	329	100.0
Marital status		
Marriage	278	84.5
Divorced	11	3.3
Widowed	28	8.5
Single mother	12	3.6
Total	329	100.0
No. of children		
None	43	13.1
1-5	206	62.6
6 -10	63	19.1
11 -15	17	5.2
Total	329	100.0

The result in Table1 presents the socio-demographic characteristics of the respondents concerning age, marital status and the number of children. Concerning the age, the data showed that 39.2% of the respondents are within their late youthful age (28-37), 29.2% of the respondents are within their early youthful age of (18-27), 20.4% of the respondents are within the age of 38-47 and 10.6% of the respondents were elderly (48 years and above). As at the time the study was conducted, it was a period when maternal mortality was prevalent in Yauri. Women of all ages are becoming concerned about the phenomenon. After all, they are affected directly since they are in the childbearing age or indirectly because their children and siblings are in the childbearing age.

Concerning marital status, the table shows more than half of the respondents were married with 84.5%, as against 8.5% of them were widowed, 3.6% were single mothers while the Divorced constituted 3.3%. From this result, most of the respondents in the Yauri were married. Therefore, they have experience of childbirth. With respect to the no. of children, the data showed that 62.6% of the respondents had between 1-5 children, 19.1% had between 6-10 children, 13.1% of the respondents never had children while 5.2% had 11-15 children. Hence, the majority of the responses of this research had between 1-5 children which means that have had childbirth experiences between 1-5 times and have experiences to share.

Table 2: Ethnicity, Religion and Highest Educational Attainment

Ethnicity	Frequency	Percentage
Hausa	217	66.0
Yoruba	24	7.3
Igbo	10	3.0
Others	78	23.7
Total	329	100.0
Religion		
Islam	297	90.3
Christianity	28	8.5
Others	4	1.2
Total	329	100.0
Highest Educational Attainment		
Informal education	63	19.1
Primary education	114	34.7
Secondary education	92	28.0
Tertiary education	43	13.1
others specify	17	5.2
Total	329	100.0

Table 2 presents the continuation of socio-demographic characteristics of the respondents with respect to ethnicity, religion and highest educational attainment. The result on ethnicity shows that majority of the respondents are Hausas with 66.0%, followed by others with 23.7%, Yorubas constituted 7.3%, and the Igbos constituted 3.0%. This implies that majority of the residents in Yauri were Hausas which suggested that the study area was dominated by the Hausas since it is in the Northern part of Nigeria. Also, a substantial number of respondents which is 90.3% practice Islam, 8.5% practice Christianity while 1.2% practice other religion. From the result, Islam was found to be the dominant religion among the respondents. Also, a walk around the Yauri revealed that there were mosques in almost every street compared to churches or other religious institutions. In addition, the study found that 34.7% of the respondents had primary education,

28.0% of the respondents had secondary education, 19.1% had informal education, 13.1% had tertiary education while 5.2% had other forms of education. From the result, most of the women in the study area had low educational attainment because they only had primary education.

Table 3: Occupation and Income per Month

Occupation	Frequency	Percentage
Petty Trading	199	60.5
Civil servant	87	26.4
Others	43	13.1
Total	329	100.0
Income per month		
Less than N1,000	158	48.1
N1,001 – N10,000	34	10.3
N 10,001 - N 20,000	21	6.4
N 20,001 - N 30,000	8	2.4
N 30,001 and above	108	32.8
Total	329	100.0

Also, the result in Table 3 presents the continuation of socio-demographic characteristics of the respondents with respect to occupation and income. In terms of occupation 60.5% were into petty trading, 26.4% were civil servants, while 13.1% had other occupations. The result, therefore, found that many of the women were at home engaging in petty trading like their availability suggests that they are more likely to get pregnant frequently.

In respect to their income, almost half of the respondents 48.1% of the respondents earn less than ₦ 1,000, 32.8% of them earned from ₦ 30,000 and above on monthly basis, 10.3% of the respondents earned within the range of ₦1,001- ₦10,000, 6.4% earned within ₦10,001- ₦20,000, 5.5% earn less than ₦ 1,000 while 2.4% of the respondents earned within ₦20,000 and ₦30,000. This result, therefore, means that many of the women in the area are not earning any income. They, therefore, have to depend on others such as their husband for financial support when pregnant.

Culture and Maternal Mortality

All the table in this section examined some cultural practices that may likely lead to maternal mortality in Yauri Emirate.

Table 4: Cultural Factors

Our community is a patriarchy community	Frequency	Percentage
I don't know	0	0.0
No	0	0.0
Yes	329	100.0
Total	329	100.0
Only my husband takes health related decisions for me		
I don't know	0	0.0
No	95	28.9
Yes	234	71.1
Total	329	100.0
Seeking medical services without my husband's permission or presence is not acceptable		
I don't know	0	0.0
No	13	4.0
Yes	316	96.0
Total	329	100.0
I use herbal medicine, leaves and root during pregnancy		
I don't know	0	0.0
No	124	37.7
Yes	205	62.3
Total	329	100.0
I sometimes use traditional birth attendants during delivery		
I don't know	0	0.0
No	150	45.6
Yes	179	54.4
Total	329	100.0

Table 4 contain the result of the roles of stakeholders in curbing the prevalence of material mortality. With regards to this results, 100% of the respondents indicated that our community is a patriarchy community, a system where the father is the head alongside the authority of the family, which implies that the wife and children are controlled by the father. Again, 71.1% of respondents indicated that their husbands takes health related decisions for their families and 28.9% of respondents indicated that their husbands do not take the decision of health related matter in the family, and this implies that men are the final authorities in majority of homes as

regard health related matters. So also, 96.0% of respondents indicated that seeking medical services without their husband's permission or presence is not acceptable where as 4.0% of the respondents indicated that without their husbands consent, medical services can be carried out or attained to. Which implies that husbands are the major determinant or authorities on medical services in homes. This corroborated by the findings of the interview.

Traditionally and also religiously the husband is the head of the home. Health issues are major issues that calls for consultations and critical deliberations so taking such decision behind your husband is not good more so is will be the one to pay for those bills as I mentioned to you the other time. We usually encourage our women to deliberate with their husband and carry them along since they are one family.(KII/Traditional Leader 1).

Also, another participant indicated that:

My wife doesn't take any decision without me and this is what our culture has taught us it is a sign of respect and regards for me. A man whose wife takes decision on her own cannot control his home period. (KII/Husband)

Likewise, 62.3% of the respondent indicated that they use herbal traditional medicine during pregnancy where as 37.7% of the respondents indicated that they do not use the traditional herbal medicine during pregnancy. These implies that majority of pregnant women go for the traditional herbal medicine. Again 54.4% of respondents indicated that they sometimes use traditional birth attendant during birth, meanwhile, 45.6% of the respondent indicated that they do not go for traditional birth attendant during child birth. Which implies from the above estimate, that above average of the women go for traditional birth attendant during birth. In this regards some respondents opined that:

We have doctors and nurses on ground to attend to pregnant women from morning to night. The hospital doors are wide open: we are even encouraging them to come So that we can attend to them in order to reduce the skyrocketing incidences of pregnancy complications that is ravaging our community but instead, the will go to quacks who will deceive them and collect money and leave them in a more devastating condition (KII/Medical Practitioner 1).

Also, another participant indicated that:

the issue of maternal mortality is our problem especially among the uneducated due to massive ignorance (KII/Medical Practitioner 2).

Another participant indicated that:

Many of the men and women in this community are not well educated making it extremely difficult for them to have full grasp of some health implications of their actions which is making our women take things that are not prescribed by doctor (KII/Traditional leader 1).

Hypothesis Testing

HO: Delay in Decision does not significantly affect the rate of maternal mortality in Yauri

H1: Delay in Decision significantly affects the rate of maternal mortality in Yauri

Table 5: Summary of regression analysis showing the relationship between Delay in Decision and rate of maternal mortality

	B	Std. Error	Beta	T	Sig
(Constant)	16.403	1.220		13.445	.000
Access to antenatal care in our health care centre	-.922	.212	-.230	-4.343	.000
Poor experiences with the health care centre	-1.516	.597	-.264	-2.540	.012
Poor understanding or knowledge of the complications and risk factors in pregnancy	1.221	.267	.450	4.578	.000
Lack of money to pay for health care services	.132	.152	.046	.864	.388
Waiting for husband before seeking health care services	.315	.189	.096	1.665	.097

(R = .411^a; Adjusted R2 = .156; F= 13.104; Sig. 0.000^b; df =5)

Table 5 shows the simple correlation between delay in decision and rate of maternal mortality (R) of .411^a. The simple correlation result shows that as the delay in decision persist the rate of maternal mortality will increase. The relationship between the two variables is moderately positive. A multiple adjusted R square of 0.156 in the result means that 15.6% of the variation in the rate of maternal mortality is accounted for by delay in decision.

The effect of the joint contribution of the independent variable (delay in the decision) on the dependent variable (rate of maternal mortality) was significant (F = 13.104; df = 5; 329: p<0.05), which means that our regression model effectively predicted the outcome. Furthermore, the Table reveals the relative contribution of the components of the independent variables to the dependent variable, which are expressed in Beta weights and t-test.

risk factors in pregnancy made the most significant relative contribution to rate of maternal mortality (B = .450, t = 4.578 (329); p<0.05) followed by access to antenatal care in our health care centre (B= -.230, t = -4.343 (329); p<0.05) this is followed by Poor experiences with the health care centre (B= -.264, t = -2.540 (329); p<0.05) this is followed by Waiting for husband before seeking health care services (B= .096, t = 1.665 (329); p>0.05) this is followed by Lack of money to pay for health care services (B= -.046, t = 0.864 (329); p>0.05) respectively. Therefore, risk factors in pregnancy, access to antenatal care in the health care centre and Poor experiences with the health care centre had a significant effect on the rate of maternal mortality. These findings corroborate the KII interviews.

Firstly, that the risk factors in pregnancy are one of the major factors that lead to maternal mortality. Based on both the quantitative and the qualitative results, many of the women in the study area have poor understanding or knowledge of the complications and other risk factors like waiting for husband before seeking health care services, this makes it very difficult for them to know the next step to take and once there is a delay in taking appropriate measures, mortality is inevitable. Some of the Participants revealed that:

... Another factor that negatively affect woman during pregnancy is lack of proper information on health care facilities that are available. (KII/Medical Practitioner 1).

Many pregnant women are carrying infection in their bodies and they are not aware of the symptoms and the implications while they may not even know the type of food that can constitute risk during pregnancy. This is why many of the women in the study area have been collectively described by all the stakeholders as ignorant. Secondly, access to antenatal care in our health care centre delays decision making which in turn leads to maternal mortality. Even though many of the respondents in the quantitative studies claimed that they have access to the health care facilities but when the indicators for measuring access were considered it was obvious that they were ignorant of what it means to have access to health care. They only thought that the existence of a building called a health care centre is synonymous with having access to health care. The KII result showed that the road network to those health care centres was bad which discourages the commercial motorcycle and tricycles from patronizing the axis even when the prices are cheap. In a bid to buttress this position of the quantitative study, one of the district heads in the study indicated that

...our people living in the rural areas find it difficult to access health facilities due to heavy downpours that damage the road network. (KII/Religious leader).

This is a pointer to the fact that it is possible for the women to have the transportation fee but not find any transport that would take them. It is equally possible to find transport but due to the poor condition of the road the women experience complication while being transported. The third issue that was found was that many of the women have had poor experiences with health care. This situation was not identified by all the stakeholders who only rated the experiences at health care as fair but recommended that there was a need for improvement. Hence, there is a need to further examine the experience of pregnant women in the health care facilities in Yauri.

The study, therefore, rejects the null hypothesis which states that delay in the decision does not significantly affect the rate of maternal mortality in Yauri and accepts the alternative hypothesis which states that delay in decision significantly affects the rate of maternal mortality in Yauri.

Discussion

The study found out that ethnicity is a significant variable that significantly affects the rate of maternal mortality. The Hausa culture strictly expects the wife to be dependent on the husband and stipulates that the husband is the final decision maker and the wife has no right to take major decisions until she consults her husband. In this case, the woman is helpless during emergency if her husband is not around or if he refused to give her permission to receive urgent care. This has accounted for several deaths in the study area. This finding corroborated the findings of Ujah et al. (2005), that Culture also determined gender norms that deny women the ability to make their own decisions, seek care without their husbands' or other family members to make decisions on their own contributes to maternal mortality.

Also, this study found that delay in decision significantly affects the rate of maternal mortality in Yauri. This corroborates with WHO (2002) findings that greatest burden of health risk is very often borne by the disadvantaged in our societies. In other words while women generally experience poor health status probably because of their biological conditions or other socio cultural factors affecting them. The point here is that, while women generally may have low health status, rural women because of inaccessible, unavailable health care services, lack of education, poverty and traditional beliefs are more likely to have poorer health status.

Conclusion

Based on the findings of the research, it is concluded that ethnicity is one of the major challenge maternal health because most of those that are in the study area are Hausa many of them still have the Hausa mentality that their wives should not engage in any occupation rather than looking after the home. The finding of this study constitute a setback for the family as the man bears all the financial pressure.

The study also concluded that delay in decision-making has also contributed to the rise in the rate of maternal mortality in Yauri. Some of the factors that influence the women's decision to access those healthcare facilities are their poor understanding of the risk factors in pregnancy, many of them do not even have access to antenatal care in the health care centre and even those that have access to the health care centres are still trying to overcome their trauma associated with the poor experiences. This made it very difficult for many of them women to think of going to the health care centre as an immediate option. Hence, the basis for the delay and it is important to note that during pregnancy no sign or symptom can be taken for granted if it is not promptly attended to, it can cause serious consequences. This is why the rate of maternal mortality in the study area has skyrocketed.

Recommendations

To curb the growing rate of maternal mortality in Yauri Emirate, the traditional rulers should encourage the proper prescription of herbal medications for women during pregnancy since some of the women prefer herbal medication but they do not know how to use them correctly. More importantly, to curb the growing rate of maternal mortality in Yauri Emirate pregnant women should speak out when they have issues during pregnancy or even after they have delivered so that they could be quickly addressed instead of keeping silent.

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