



Sociocultural practices in maternal health among women in a less developed economy: An overview of Sokoto State, Nigeria

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Abstract

This study explores sociocultural and traditional practices associated with maternal health in Sokoto state, Nigeria. These practices play significant roles in the life of women folks in the zone. Past researches show that Nigeria is culturally diverse with over 300 different ethnic or linguistic groups and dialects. In this study, sources of data and information include field observations, current literature in international journals, other academic researches, government publications, United Nation reports, USAID resources, and Pathfinder International materials. The findings reveal that tradition-inspired practices and norms such as unattended labour and delivery, low level of education, hot-bath (*Wankan jego*) during new birth, use of herbs, forced marriage, early marriage, child spacing, female genital mutilation and traditional gender discrimination play a significant role in maternal health, and are believed to account for the high maternal mortality rates in the state. Although such practices are predominant among women with low education attainment their general influence remains strong even in the face of extensive modernisation such that they need to be addressed more squarely if maternal mortality is to be reduced. Hence, the study recommends that instead of investing in the provision of more modern health facilities that are grossly underutilised commensurate effort should be made in tackling traditional beliefs and practices among women in the state.

Keywords: health care, maternal health, maternal mortality, sociocultural practices, Sokoto state, traditional norms

Introduction

One of the major maternal health challenges facing Nigeria particularly in the northern states is the dominance of cultural and traditional practices arising from women in different ethnic groups of the country. Specifically, Sokoto State is one of the states with high maternal deaths in the north western zone. The state is dominated by Hausa and Fulani ethnic groups co-existing together as indigenous of the area. Nigeria is a patriarchal society and Sokoto state is not an exception. The patriarchy influences all aspects of social life and relationships particularly in seeking for health services by the women folks. Eventually, Nigeria is a country of great cultural diversity consisting of over 300 different ethnic groups with an equal number of distinct languages and dialects. In Sokoto state, the determinants of maternal health and subsequent mortality extend beyond health care delivery. Most maternal mortality cases can be attributed to sociocultural factors includes cultural and religious influences and other social factors that affect individual preferences. There are demand factors that can be controlled at the community, household or individual levels which are amenable to policy intervention (Tim Ensor & Cooper 2004). Although, individual characteristics that determine need, such as age and sex are not considered since they cannot be controlled (Tim Ensor & Cooper, 2004). Nevertheless, culture can be described as central to the existence of any society on earth without which there will be no language of expressions, self-

consciousness and ability to think or reason (Fawole, 2006). While Nayak et al. (2012) refer to culture as values, beliefs, and behaviours that are shared by members of a society and which provide direction for people as to what is acceptable or unacceptable in given situations.

Researches have shown that on average in Nigeria, urban population constitute 50% of total population and most Nigerians (irrespective of where they live) are strongly influenced by the cultural and traditional norms of their ethnic origin. So also, it is obvious that basically there are two dominant ethnic groups in Sokoto state; Hausa and Fulani groups, but within these groups there are sub-categories each with specific norms and value attached to it. This explains the differences in sociocultural behaviours that affect the lifestyles of entire society (Majali, 2012). In addition, he further expatiates that sociocultural factors can have an influence on individual behaviours depending on one's social values. Such social values could be religion, economic status, education, family, politics and cultural values as well. Therefore, this study discusses the norms, values and practices in maternal health, early marriage, child spacing, gender inequality and female genital mutilation. Norms are the specific cultural expectations or agreed-upon expectations and rules by which the members of a culture behave in a given situation for instance practices such as early marriage and traditional maternal health practices. There are four basic types of norms that sociologists commonly refer to: folkways, mores, taboos and laws. But values can simply be explained as those elements of your life which you find personally important e.g child spacing and female genital mutilation whereas beliefs are the assumptions we make about ourselves, about others in the world and about how we expect things to be for instance gender inequality (see Table 2). These practices are believed to be stopgaps in the use of modern maternal health facilities thereby accounting for high maternal mortality rate in the state.

Study area

Sokoto State is one of the 36 States that make up the Federal Republic of Nigeria. It lies geographically between longitude 11° 30" to 13° 50" E and latitude 4° 00" to 6° 00" N (Shamaki, 2005). The state has a total area of 27,825 square km and 23 local government areas. It shares boundaries with the French speaking West African States of the Republic of Niger to the north and west, to the east and south, with the Nigeria's states of Kebbi and Zamfara respectively. Records show that the state was first created from the former North Western region in (1976) and covers a total area of 102, 500 square km (Shamaki, 2005). Presently, the state has a projected total population of 4,556,920 (males 2,293,690 and females 2, 263,230). Two major ethnic groups comprising Hausa and Fulani are found to be dominant and indigenous in Sokoto state. However, there are Zabarmawa, and Tuareg minorities residing in the border local government areas. Over 80 percent of the people in the state practice agriculture as their major source of income while local crafts like black smiting, weaving, dyeing, carving and leather works forms the remaining 20% (SSG, 2012).

The development of Sokoto is traceable to the Fulani Jihad of the early 19th century. It was probably a hamlet temporarily settled by some nomadic or peasant group when the Fulani came to settle in it and eventually turned it into the caliphate capital in 1809. An Islamic reformist movement under the leadership of Sheikh Uthman Dan Fodiyo ignited a series of wars between the Hausa and Fulani armies. Began in small area of Gobir in 1804, the Jihadist conquered most of what came to be known as Northern Nigeria today with the town of Sokoto finally chosen as the capital of the caliphate. Given the historical significance of the Sokoto, it still remains very prominent centre in the practice of Islamic religion in Northern Nigeria and the entire West Africa as a whole. Fulani's and Hausa's cultures formed the main thrust of way of life of people in Sokoto state. This is because the Hausa and Fulani people are the most dominant ethnic groups in the region and their culture are therefore widely practiced. In fact, the dominance is not only within the Sokoto region but the entire Northern Nigeria (see Figure 1 shows the principle ethnic groups in Nigeria). Hence, the sociocultural practices in maternal health among women in the state, other than religious factors, are not different from those practiced elsewhere in Northern Nigeria (SSG, 2012). Since, culture is the way of life way of life, the Hausa and Fulani culture predicts many of

the societal beliefs including gender roles and responsibilities in the Sokoto region (Abdul et al., 2012). They added that culture and tradition continue to exert overbearing influences on Nigerian women and deny them their fundamental human rights.

However, the importance of ethnicity in influencing sociocultural practices of women in the region cannot be underestimated. Child marriage is a common practice among all the ethnic groups in Nigeria but is more rampant in the Northern region especially among the Hausa culture in Sokoto state (Abdul et al., 2012). Also, very peculiar to this zone is that most early marriage was practice with a girl not exceeding three menstruations (*Haila*) at home before getting married (Abdul et al., 2012). In fact, the Fulani culture entails that marriage takes place when the boy is between the ages of 17 and 20 years and the girl is between the ages of 13 and 15 years (UNFPA, 2008). While in the traditional Hausa society, the boys were expected to marry between the ages of 17 and 23 years whereas most parents gave out their daughters in marriage between the ages of 12 and 15 years (UNFPA, 2008). This could even be less among the rich family. Another thing that becomes a cynosure among most Hausa and Fulani youth in the marriage is the process or courtship (*kame*). During courtship the boy was expected to give the girl some gifts each time he visited the girl or during festivities such as the *Sallah/Hari Raya*. This process makes both parties proud and continues to attract them into marital life especially in the uneducated societies. Apparently, this is now supported by a common phenomenon known as “consanguineous marriage” which is the marriage between two close relatives. In such a case, the bride and the groom may be cousins and in some instances their consent is not considered before such marriage are conducted. Nigeria is a high ethnic diversity as the country is occupied with over two hundred and fifty different ethnic groups and languages with Hausa, Yoruba and Igbo as the three biggest groups (UNFPA, 2008). Figure 1 shows the principal ethnic groups in Nigeria and the areas occupied by Hausa and Fulani culture.

Method of study

This study reviews various and current secondary data and information from relevant sources. These include United Nation Population Funds-UNFPA, Targeted State High Impact Project (TSHIP) of the USAID, Pathfinder International, government official documents particularly publication of the Ministry of Budget and Economic Planning Project Coordinating Unit of the Sokoto State. Information also gathered from various tertiary sources such as relevant text books, academic researches and journal article particularly International Journal of Nursing and Midwifery. Based on the information obtained, it is established that most Hausa and Fulani’s norms, values and traditional practices are generally highly acceptable and practice in the state. This is more pronounced all over the areas dominated by Hausa and Fulani linguistic groups as indicated in the map of Nigeria below. Hence, the high rate of maternal mortality can only be reduced by putting on ground bold steps to change human behaviour and attitude towards health in Sokoto State.



Fig. 1. Nigeria showing the principal ethnic groups and their regions

Factors of maternal health services utilisation in developing countries

Decision making is a progress step towards utilisation of maternal healthcare across the world. In most developing countries, this is determined by sociocultural factors especially beliefs and religion among uneducated women. Although Islam recognises the right of women in seeking basic needs including knowledge/education and healthcare, in many traditional societies where men are more dominant, women's right/needs are often denied. There are several sociocultural factors that explain why millions of women in the world lack access to adequate care during pregnancy. The inadequacy of access and under-utilization of modern healthcare services are major reasons for poor health in certain ethnic groups in Asia and Africa. Several Asian studies suggest that underutilization of antenatal care (ANC) is because of lack of women's autonomy in making decision about utilisation of the service. Social ties of rural Indian women with others may influence their decision to seek ANC by exposing them to different ideas and by imparting information about providers (Kumar et al., 1995). In a later study, Pallikadavath et al. (2004) asserts that women's autonomy was positively related to use of ANC in rural north India. Matsumura and Gubhaju (2001) show that in Nepal, women from male headed households were significantly less likely to use ANC. In other instance, Bibha Simkhada et al. (2008) highlights that the perception of pregnancy as a natural process that only warranted ANC when problems arose as such ANC was not seen as essential unless there was physical discomfort during pregnancy and complications in previous pregnancy or childbirth. They added that one reason for not attending ANC at first trimester was fear associated with the local belief that the early period of pregnancy was most vulnerable to witchcraft.

Several African studies also indicate similar findings. For instance, Bibha Simkhada et al. (2008) reveal that in Hausa culture; 'God's Will' was the strongest factor in non-utilization of health facilities in Nigeria. Other factors include women's education, husband's education, parity, birth order and interval, intended and planned pregnancy, age of women at marriage or at pregnancy, marital status, religion, caste and ethnicity, family size, and knowledge of family planning and ANC. Adamu and Salihu (2002) state that husband's refusal was one of the major reasons for non-utilization of ANC in Nigeria especially in the northern part. Studies from Rwanda, Tanzania and South Africa indicate a threefold increase in the risk of HIV amongst women who have experienced violence compared to those who have not. In turn,

HIV-positive women have been found in some populations to be about four times more likely to die in pregnancy or childbirth than a woman without HIV (Hc, 2008). In a survey in Senegal, researchers found that in more than half of the cases decisions on care-seeking for women were made by the husband or other senior family member (Tim Ensor & Cooper, 2004). Some women booked ANC very late because they were unsure whether they were pregnant or not. Similarly, lack of satisfaction with quality of care could be a major demotivating factor in the use of maternity care facilities. In Kenya, complaints about the services offered included shortage of drugs and essential supplies, lack of commitment by staff, poor quality of food and lack of cleanliness (Bibha Simkhada et al., 2008). Also in Ghana, mothers' years of formal education is one of the most frequently found determinants of use of maternal health services and similarly, health knowledge explains a portion of the association between maternal education and child nutrition in Bolivia (Greenaway et al., 2012)

Marital status and religion also had an influence on determining the use of antenatal care (ANC) and married women were 40% more likely to receive ANC from a health professional than unmarried women (Mekonnen & Mekonnen, 2003). They also found that rural women were less likely to use the service. This means that maternal healthcare programmes should be expanded and intensified in the rural areas along with culturally-appropriate education campaigns. In sub-Saharan Africa, partly because of the lineage system and partly because of widespread polygyny, wives usually have separate budgets from those of their husbands and are themselves responsible for many of the resources needed by their children (Caldwell, 2008). Therefore, a strong cultural tradition limiting women's autonomy, especially when reinforced by a religion that regards the seclusion of women as a prime moral objective, can have a deleterious effect both on female health in general and on all child health because of the limitation in mothers' taking quick and effective action.

Of the world's estimated annual 130 million births, some 60 million births occur at home each year and the pregnancy outcomes appear considerably worse than births that occur in a medical facility (Garces et al., 2012). Consequent upon that, a study using a sample of birth attendants conducting home or out-of-facility deliveries in 7 sites from 6 countries (India, Pakistan, Guatemala, Democratic Republic of the Congo, Kenya and Zambia) has been carried out. The results reveal proportion of births occurring at home ranged from 14% in Nagpur, India to 74% in the Equateur Province of DRC (Garces et al., 2012). Thorough investigations have shown that most of these home births were due to sociocultural behaviour as many were attended by family members or were unattended especially in Zambia and Kenya (Garces et al., 2012). However, in spite of a slow reduction rate and high geographical inequality in global MMR in the past 15–20 years, exciting progress has been made in many developing countries and many efficient interventions have been proved to remarkably reduce MMR in many developing countries. Examples include strengthening control of infectious diseases in Sri Lanka, conducting of contraceptive strategies in Bangladesh, improving accessibility to in-hospital care and midwife services in Malaysia, Thailand, Egypt and Honduras as well as the Maternal Mortality Reduction Strategy in Mongolia (Liang et al., 2012)

Moreover, cultural factors apparently affect the utilisation of maternity care services in developing countries. For instance, Azuh (2012) reports that in many parts of Africa women's decision making power is extremely limited, particularly in matters of reproduction and sexuality. He further ascertains that issues such as low status of women and husband's domination all worsen the ugly and poor utilisation of health care services. Similarly, Hubert (2013) asserts that high levels of maternal mortality are strongly correlated with high levels of social inequality, especially unequal access to health services. In addition, he added that in Mexico most of the maternal deaths could have been prevented as well if the women have had adequate prenatal care. All these could be the reasons why utilisation of health facilities is low in developing economies such as Sokoto state, Nigeria and the rest part of the world with low proportion of educated women.

The state of maternal health in Sokoto

World Health Organisation defined maternal death as the “death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes” (SSG, 2012). In fact, maternal mortality rate in Northern Nigeria is one of the highest in the world and between 1990 and December 1999, Audu et al. (2002) reveals maternal mortality rate in Sokoto as 2,151/100,000 live births and concludes that maternal mortality ratio was high in the state. Presently, the maternal mortality rate (MMR) is 900/100,000 live births as indicated by survey conducted in 2007 by UNFPA which is still quite high than the national average of 840/100,000 live births (SSG, 2012). Records have shown that the access and utilisation of maternal services is not very encouraging in Sokoto state. The situation as reported in the NDHS (2008) shows that 95.3% of women of reproductive age (15-49 years) who delivered within the five years of the survey had home delivery and only 4.4% in a health facility. So also, in terms of utilisation 60.0% of them had one or more challenges accessing health care. These, included lack of money to pay for services, non-availability of provider at the facility and where a male provider is available there is reluctance to visit such provider due to cultural behaviour, and the perennial lack of essential drugs in the facilities. Table 1 highlights the indicators of health facility assessments on staffing and maternal health services in Sokoto state.

Table 1 Indicators of health facilities assessments

Staffing	Indicator	%	Sample size
<i>Maternal Health Services</i>			
4	% of health facilities that offer maternal services	58.1	124
5	% of health facilities that offer ANC services, of those that offer maternal services	98.6	72
6	% of health facilities that offer delivery and postnatal care services, of those that offer maternal services	84.7	72
7	% of health facilities that provide AMTSL (use of oxytocin, uterine massage and control cord traction), of those that offer PNC/delivery services	47.5	61
8	% of health facilities that provide treatment of eclampsia (use of magnesium sulphate, diazepam, and anti-hypertensive drugs), of those that offer PNC/delivery services	1.6	61
9	% of health facilities that provide treatment of postpartum haemorrhage (use of egometrin, oxytocin, and antishock garment), of those that offer PNC/delivery services	8.2	61
10	% of health facilities that perform essential new-born care (use of clean cord care, drying and wrapping, and immediate breast feeding), of those that offer PNC/delivery services	77.0	61

Source: TSHIP, 2010

Sociocultural factors in maternal health in Sokoto

Although Nigeria is experiencing rapid economic growth, the sociocultural milieu especially the structure of the family, incorporates both traditional and modern elements in utilisation of maternal facilities (NAS, 2009). Both stresses in different ways of life to the extent that different groups in a single city or state exhibit maternal mortality regimes characterizing populations with expectations of life at birth as far apart as 45 and 70 years. The sociocultural factors remain very strong in Sokoto state even in the face of

extensive modern development, including all-embracing public health measures and social reforms. These are institutionalized norms and values of the society in which individuals are guided in their actions relating to utilisation of maternal health facilities. Indeed, such factors are legion and pervasive, and usually have ethnic, religious, cosmological and spatial dimensions across the state.

The sociocultural milieu of maternal mortality in Nigeria and Sokoto in particular is intensified by a high level of illiteracy as well as social inertia among women's population which continues to tie the modern to the ancient (NAS, 2009). Some of the sociocultural underpinnings of high levels of maternal mortality in Nigeria are women illiteracy, the belief system about disease, the patriarchal system and the low status of women (see Table 2). In fact, maternal mortality varies considerably by various socioeconomic and cultural variables. And, of them all, maternal education was found to be the single most significant determinant of marked differences in child mortality among women in the zone. According to the report by Pathfinder International (2013), the level of women's literacy in Nigeria is exceedingly low in the northern region, especially the North East and North West where Sokoto state belongs. Two important factors influencing the effectiveness of the female voice in household decision-making are the extent to which female members are educated and contribute to household income (Tim Ensor & Cooper, 2004). Comparison in the country shows that about 90% of women have at least primary education in the southern region, but only 25% to 30% of women in the North East and North West regions have the same level of education. Again, women's exposure to mass media is also lower in the northern region and in spite, of all that women bear about seven children, most of whom are wanted, compared to only four children in the southern region of the country.

Educated mother is more capable of manipulating the modern world because she is more likely to be listened to by doctors and nurses at any given health facility. Her level of exposure can prompt her to demand for health workers attention even when they are reluctant to provide essential services. Therefore education of women greatly changes the traditional balance of familial relationships, with profound effects on maternal health care. This is more common among highly literate and urbanised population. Eventually, over 60% of the population in Sokoto state is rural and many rural families exhibit a weak husband-wife relationship by a variety of mechanisms that include inability of the wife to communicate easily with her husband, a maternal role of indulgence, and a husband/father role was authoritarian (NAS, 2009).

The distance travel and finance greatly affects access and utilisation of maternal health facilities in Sokoto state. Several studies have shown large proportion of population in the state live in rural areas with high levels of poverty among most women. Thus TSHIP (2010) reveals that 65.9% of women reported problems in getting money for utilisation of health facilities while 23.7% reported difficulty in accessing care due to the distance to the facility. Similarly, 58.3% of women cannot utilise the health care facilities due to non-availability of female providers (TSHIP, 2010). This re-affirms that the place of residence is a significant determinant of both availability and utilisation of maternal health care facilities in Sokoto state. Previous study by Shamaki and Katiman (2013) indicates that most facilities in Sokoto state are concentrated only in the urban Sokoto state. This phenomenon could distant perceptions of health issues related to pregnancy and continues to aggravate the high rates recorded in maternal deaths in the state due to practices of traditional method (see Table 2). Earlier studies by Chuku (2008) emphasised that women's perception of their pregnancy will reflect their cultural background and status within the family and community. Even when pregnant women gain access to antenatal care, the conflict with traditional and cultural views on suitable medications for use in pregnancy is a considerable factor affecting their utilization (Chuku, 2008).

Although it all depends on the individual's wisdom in practices of religious issues, the religion which can be seen as sociocultural in Nigeria also determines health care access and utilization to some extent especially for religiously and traditionally inclined women. This is confirmed by TSHIP (2010) which reveals that in Sokoto state many women are not allowed to go to hospital or clinic without their husband's permission, and this can endanger their lives if they are experiencing a medical emergency. In Nigeria, the Northern parts are Muslim-dominated areas especially Sokoto state which is the centre of the Caliphate (*Amirul Mumineen*) therefore, the beliefs among pregnant women in relation to disease and

antenatal care need to be well understood if antenatal care and related services are to have their optimum impact. To do that policy makers should have a sound understanding of the role of sociocultural factors in influencing health care seeking among women in the state. Table 2 shows the classification of cultural practices according to norms, values and beliefs among women in Sokoto State.

Table 2. Sociocultural practices affecting maternal health services in Sokoto, Nigeria

Type of Practice/Method	Category	Classification	Consequences and Impacts
Purdah	Early marriage	norms	Prevent women from seeking healthcare, restrains women going out, deter socialisation, Early marriage leads to VVF and obstructed labour at times
Use of herbs in pregnancy and birth	Family planning/maternal health	values	Discourage use of modern methods
Putting fertiliser under pillow during mating	Family planning	values	Discourage use of modern methods
Use of waistbands (<i>guru</i>)	Family planning	values	Discourage use of modern methods
Squeezing and drinking lemon	Family planning	values	Discourage use of modern methods
Drinking potash	Family planning	values	Discourage use of modern methods, medical implication
Feeding prohibition during pregnancy and birth	Maternal health	norms	Malnutrition and health risks
Unattended labour and delivery	Maternal health	norms	Susceptibility to complication and maternal deaths
Husband's prohibiting wife to hospital	Maternal health	norms	Lower use of modern health facilities
Hot-bath (<i>wankan jego</i>)	Maternal health	norms	Discourage use of modern methods, medical implications
Female genital mutilation-FGM	Cultural practice	values/beliefs	Complications such as urine retention, urinary tract infections, infertility, painful intercourse, psychological and sexual problems, prolong labour, perinatal outcomes etc.
Gender discrimination	Gender inequality	beliefs	High rate of poverty and low education among women, low education of women, intimate partner violence, lower status of women, women's lack of autonomy and mobility, disempowerment of women to men, lack access to job by women etc.

Although cultural norms such as purdah restrictions, can prevent women from seeking health care outside the home for themselves and their children, this barrier is often raised still further when men carry out the tasks of providing maternal services at the health centre instead of women. This behaviour is prevalent in Sokoto state and has been noticed as one reason why Asian women living in Western countries often make little use of health services (Tim Ensor & Cooper, 2004). Similarly, it is culturally unacceptable for women to leave their homes for long periods hence distance was a much greater barrier to women than to men with similar incomes in seeking health care. Other socio-cultural norms strongly affect women's experiences of pregnancy and childbirth (Hc, 2008). Female genital cutting substantially increases the risk of delivery complications for women (Hc, 2008). Another example of culture as a

barrier to using services elsewhere is the perception among the Alur people of Uganda and the Bariba tribe of Benin republic that help with delivery indicates 'weakness' and another is the unacceptability of modern contraception among men in parts of Pakistan (Tim Ensor & Cooper, 2004).

There is no doubt that culture and ethnicity create a unique pattern of beliefs and perceptions as to what "health" or "illness" actually mean. In turn, this pattern of beliefs influences how symptoms are recognized, to what they are attributed, and how they are interpreted and affects, how and when health services are sought (Abdul et al., 2012:8). Almost 40 years ago Suchman accounted for ethnic differences among people seeking health care as related to social structures and relationships and the degree of scepticism about professional medical care. Delay in seeking care was found among individuals belonging to cultural groups characterized by ethnic exclusivity, traditional family authority, and high scepticism about medicine. According to Pathfinder International, (2013) norms such as traditional practices and use of herbs also discourage the use of more effective modern methods. Some of these traditional methods include putting fertilizer under the pillow, taking a "pill" made of dried bat's waste or using "guru" (medicinal waistband), squeezing of lemon juice and drinking it as well as drinking potash (potassium) are both health treatment and traditional family planning which prevents conception. However, studies indicate that these cultural practices are very common among Hausa and Fulani women in Sokoto state as explained in the following headings:

Maternal health

The health of women during pregnancy, childbirth, and the postpartum period is refers to maternal health. Broadly speaking, it is a health care dimensions which encompasses family planning, preconception, prenatal, and postnatal care in order to reduce maternal deaths. A report from Pathfinder International, (2013) in Sokoto zone shows that the community named several practices that affect the health of child-bearing women both during pregnancy and delivery, and after birth. These practices in some communities cover feeding and include the fact that some pregnant women are not allowed to eat certain meals or foods. Similarly, not just Sokoto but across the northern states, unattended labour and delivery is a common practice (Pathfinder International, 2013). This means that the pregnant woman delivers the baby herself in her home, and then may ask for assistance in cleaning the baby or removing the placenta from the TBA mostly a family member. Therefore, why some women do not attend ANC is because the husbands prohibit their wives from going to facilities perhaps due to the purdah system (Pathfinder International 2013). A purdah system is a tradition secluding married women from other men (Pathfinder International 2013). It is mostly practice among Muslim women in Nigeria.

However, some look at why some women do not attend ANC mainly because of financial implications involved in using health services. While it can be that others may not go for ANC largely due to a lack of understanding of the value of a health facility over what a TBA will offer for them at home. This practice constitutes the high use of TBAs and explains the low utilization of health facilities for delivery in Sokoto and the northern Nigeria. Another cultural practice as a health measure and very vital among most women is hot-bath known as "*Wankan jego*" in Hausa language. In this practice, the new mother is given a hot-bath using leaves of the neem tree twice a day for about 40 days following delivery (Pathfinder International, 2013). The leaves are usually dipped into boiled water and splashed on the body until the water runs out. Although the hot water massages the body and many women say the bath makes them feel good, if overdone, it can raise the woman's blood pressure of the practitioner (Pathfinder International, 2013). This practice reduces use of modern care as it is notable among women in Sokoto state, especially the low literate ones.

Early marriage

In a related development, rate maternal mortality is also attributed to form of marriage and its duration. Abdul et al. (2012:7) reports that in northern Nigeria, girls are force in to marriage at really young ages from nine years old and they are given to old men without their consent. This can be truth but is practice

by the patriarchal type of family system. In the other view, early marriage is regarded as an important and advantageous cultural behaviour if health issues were not been compromised particularly among the population loving society. There are two types of marriage identifiable in the traditional Hausa society in Sokoto state. These are “*Auren budurwa*” or virgin/girl marriage and “*Auren Bazawara*” or any marriage after the first marriage (UNFPA, 1998). However, irrespective of any type, Olusegun et al. (2012) state that early marriage accounts for about 23% of maternal mortality due to severe haemorrhage resulting from obstructed and prolonged labour. This is because the narrow pelvis of young women results to fistula and often times a still birth which consequently leads to haemorrhage. Many cases of VVF are seen in Maryam Abacha women and children hospital in Sokoto that confirms high cases of haemorrhage in the state.

Generally, marriage is well perceived as a means to increasing the population or Allah’s reward among the Hausa people and it connotes respect for husband (UNFPA, 1998). And, UNFPA (1998) found that among the Hausa there are cultural norms which prescribe when and who to marry, when a girl should be pregnant, when couples are expected to have their first child, intervals between births, duration of breast feeding and the general care of the baby. However, Abdul et al. (2012:8) noted that *purdah* as practiced in the northern part of Nigeria including Sokoto state restrains women from going out, socializing, working and ‘*having a life*’. This is perhaps a good conduct in line with the dominant religion in the zone. However, they live a sad life as prisoners and as such suffer from mental depression and a very withdrawn way of life; some are even unfortunate enough to not be permitted to see their relatives and friends and are beaten continuously by their husbands (Abdul et al., 2012:8). Sometimes these practices are traditional and cultural not religiously enforced, as such understanding them more will discourage the patronage and help to improve utilisation of modern services thereby reducing rate of maternal and child mortality in the state.

Family planning or child spacing

The predominant beliefs in Sokoto and other northern areas revolve around the religious conviction that God has asked people to procreate and that there should be no need to limit or stop childbearing (Pathfinder International, 2013). This belief has been strongly supported by Muslim and Christian religious leaders which indicate a general disapproval of family planning. For example, Pathfinder International reveals that an Imam in Sokoto said, “We know nobody can determine the size of the family apart from God” and a TBA in Katsina explained further that, “They believe that God gave you children and will provide for their needs.” To crown it all, a male youth in Sokoto state asserts that:

“No one should obstruct the survival of another person, after all the religion preaches that propagation of children is a blessing from God and it is disobedience on the part of anyone who practices family planning.” (Pathfinder International, 2013)

Thus children are seen as blessings and having many children enhances the social status of the household head and provides a reliable source of labour for a farming family. Hence, not only Sokoto, in most of the states, polygamy and competition among wives to produce children leads to many number of children been born. This practice makes it almost impossible to utilise modern way of family planning contraceptives thereby exposing women to more dangers of giving birth and the subsequent maternal deaths. Hence, norms such as traditional practices and use of herbs discourage the use of more effective modern methods in Sokoto state (Pathfinder International, 2013). In addition, other traditional methods (practice mostly among women with low levels of education) include putting fertilizer under the pillow with the hope of not conceiving during the mating, taking a “pill” made of dried bat’s waste or using “*guru*” i.e a medicinal waistband, to give protective properties to its wearer. And some rural or traditional society of the state, family planning strategy include that women squeeze a lemon juice and drink or drink potash (potassium) in water to prevent conception (Pathfinder International, 2013). All these practices

attract large proportion of the populace and explain the low utilisation of modern maternal health facilities thereby contributing to high maternal and child deaths in Sokoto state.

Female genital mutilation (FGM)

FGM involves surgically altering of the female genitalia (*Tsagar gishiri* or *yankan gishiri* in Hausa) for non-medical reasons (Pathfinder International, 2013; Kandala, et al., 2013). In spite of the fact that it is viewed as a very cruel practice that kills women and girls daily in sub-Saharan Africa, various studies indicate that FGM is a cultural practice that is more commonly in countries in the northern half of sub-Saharan Africa covering over 25 countries including Nigeria (Abdul et al., 2012). The implication of this practice is that it is irreversible and the effects last a lifetime (Kandala et al., 2013, Olusegun et al., 2012). In Sokoto state, the practice has been justified mostly on social and cultural grounds such as custom and tradition, purification, family honour, hygiene, and protection of virginity to prevent promiscuity (Kandala et al., 2013). Others believed that it increased sexual pleasure of husband, enhancing fertility and increasing matrimonial opportunities (Abdul et al., 2012; Kandala et al., 2013). In fact, the practice provides a lucrative business for the practitioners while on the other hand it leads to health complications. These complications caused by FGM mostly include urine retention and associated urinary-tract infections, obstruction of menses and related reproductive-tract infections, infertility, painful intercourse, psychological and sexual problems, and prolonged and obstructed labour as well as adverse obstetric, perinatal outcomes and physical and emotional health of girls and women (Kandala et al., 2013). In addition, Kandala et al. (2013) also noted there is high risk of transmission of HIV especially if infected infants and girls are cut in group ceremonies where circumcisers use the same instrument on all the initiates.

Generally there are four different FGM typology in practice that include clitoris dicotomy or type I (excision of the prepuce, with or without partial or total excision of the clitoris), excision or type II (the excision of the clitoris with partial or total excision of the labia minora), infibulation or type III (the partial or total excision of the external genitalia and stitching or narrowing of the raw labial surfaces, leaving a small posterior opening for urinary and menstrual flow) and type IV which consisting of pricking, piercing or incising the clitoris, scrapping of the vaginal orifice or cutting of the vagina (Kandala et al., 2013). In all these types, type III is the most severe with higher incidence in the northern states including Sokoto despite no any such specific studies of the severity have been carried out in Sokoto state.

Other associated physical and emotional health problems associated with FGM include suppression of feelings, repeated pain during intercourse and menstruation, bitterness and anger etc. Serious complications of this practice during childbirth include the need to have caesarean section, dangerously heavy bleeding after the birth of the baby and prolonged hospitalization following birth. All these contribute to differing levels of high rate of maternal mortality among Hausa and Fulani women in Sokoto state. As such, Olusegun et al, (2012) concludes that FGM is a risk factor for obstructed labour and a major indirect cause of maternal mortality in Sokoto state and Nigeria at large. This is because, the problem following FGM practice in Sokoto is that a scar tissue stretches poorly in child birth leading to perinatal tear and haemorrhage which accounts for maternal deaths due to inadequate emergency obstetric care especially in the rural areas.

Gender discrimination

Another important factor is gender inequality. Previous studies indicate that deeply entrenched gender inequalities exist in many low-income region where maternal deaths are high and health service utilization is low (Pathfinder International, 2013). These gender inequalities also are defined and perpetuated by social norms and culture and reflects differences in power between men and women both within the household and in the wider society (Pathfinder International 2013). The effects of this include relatively higher rates of poverty and lower levels of education among women than men as well as

women's lack of autonomy and mobility, intimate partner violence and overall lower social status and disempowerment of women relative to men (Pathfinder International, 2013). Education is a human right that should be accorded to all human beings and the importance of education cannot be over emphasized (Kamaldeen, 2012). However, in 1990, 20% of the world's primary school aged children were out of school and two-third of them are girls, while about 25% of the world's girls are not in school as at 1999 (Kamaldeen, 2012). This phenomenon is conspicuous in Sokoto state and it continues to create a greater gender inequality in the zone.

Another important factor that discriminate women in Sokoto state is lack of access to employment opportunities beyond unpaid agricultural labour on family farms. This leads to limited roles in decision making even about women's own health care (Pathfinder International, 2013). As a consequence, many conservative communities, cultural and social norms restrict women's mobility and prevent them from seeking health care. Though, the situation is improving but the inherent women's and girls' limited access to education still deprives them of the knowledge and tools to make informed decisions still exist. Depending on the level of living standard in a particular household, women get less support when they are ill than other family members. They may choose or be forced to seek treatment less often or delay seeking treatment irrespective of any adverse health consequences on them. Also, in most cases gender interacts with age to make young women vulnerable to the ill effects of gender-inequitable norms on maternal healthcare access and utilization. These norms may in turn dictate early marriage for girls which often leads to early childbearing and high total fertility making women in the state more susceptible to higher risk of maternal mortality and morbidity.

Conclusion

In conclusion patriarchy still influences all aspects of social life and relationships particularly in seeking for maternal health services by the women folks in Sokoto state. There are various sociocultural underpinnings of the high maternal and child mortality in Sokoto state the most important among which are maternal illiteracy, traditional belief system and behaviour about diseases, dominance of the patriarchal family system and the subsequent low status of women in the state. All these continue to add value to sociocultural practices in maternal health and combined with early marriage and female genital mutilation contribute to the sustained high maternal death among the dominant Hausa and Fulani women groups in Sokoto. To confound the situation, growing poverty due to lack of access to employment opportunities beyond unpaid agricultural labour at family farms and limited roles in decision making about women's own health care encourage the utilisation of traditional maternal facilities in the Sokoto society. Hence, in order to reduce the high maternal mortality rates more emphasis should be placed on devising ways that can educate the women and discourage them from resorting to the traditional sociocultural practices instead of increasing modern facilities that are grossly underutilised.

References

- Abdul MM, Onose M, Ibrahim MT, Voke-Ighoradge M, Adeyeye O, Adeleke O, Babalola A (2012) An analysis of socio-economic, sociocultural, religious, environmental, technological, language and educational factors on women's right in Nigeria. Sponsored by Spanish Agency for International Development Cooperation (AECID) and Fundación Mujeres, nawey.net.
- Adamu YM, Salihu HM, Sathiakumar N, Alexander GR (2003) Maternal mortality in Northern Nigeria: A population-based study. *European Journal of Obstetrics & Gynecology and Reproductive Biology* **109** (2), 153-159.
- Audu LR, Ekele BA (2002) A ten year review of maternal mortality in Sokoto, Northern Nigeria. *West African Journal of Medicine Jan-March* **21**(1), 74-6.

- Azuh D (2012) Sociodemographic factors influencing health programme usage by pregnant mothers in Nigeria: Implications for policy action, demography and social statistics program. Covenant University, Ogun state, Nigeria
- Bibha Simkhada, Edwin R. Van Teijlingen, Maureen Porter, Simkhada P (2008) Factors affecting the utilization of antenatal care in developing countries: Systematic review of the literature. *Journal of Advanced Nursing* 61 (3), 244–260.
- Caldwell JC (2008) Cultural and social factors influencing mortality levels in developing countries. 510, 44-59 [cited 14/08/2008]. Available from: <http://www.jstor.org/stable/1046793>.
- Chuku SN (2008) Low birth weight in Nigeria: Does antenatal care matter? Research for Masters of Arts in development studies. Institute of Social Studies, Graduate School of Development, The Hague The Netherlands, November 2008.
- Fawole OA (2006) Sociocultural factors affecting perception of Ill-Health in Nigeria. *Ilorin Journal of Sociology* 2 (2), 245-257.
- Garces A, McClure EM, Chomba E, Patel A, Pasha O, Tshefu A, Esamai F, Goudar S, Lokangaka A, Hambidg KM, Wright LL, Marion Koso-Thomas CB, Waldemar Carlo, Edward Liechty, Patricia L Hibberd, Sherri Bucher, Goldenberg RW (2012) Home birth attendants in Low Income Countries: Who are they and what do they do? *BMC Pregnancy and Childbirth* 2012, *Open Access* 12 (34), 1 - 9.
- Greenaway ES, Leon J, Baker DP (2012) Understanding the association between maternal education and use of health services in Ghana: Exploring the role of health knowledge. *NIH Public Access* 44 (6), 733–747.
- Hc (2008) Maternal health: Fifth Report of Session 2007–08. Committee, I. D. London, Authority of the House of Commons. I.
- Hubert C (2013) Maternal mortality trends in Mexico: State differences. Population Research Center, Chubert@Pr.UTexas.Edu. Texas, University of Texas at Austin.
- Ensor T, Cooper S (2004) *Overcoming barriers to health service access and influencing the demand side through purchasing*. HNP Advisory Services, Washington, DC. Available from: healthpop@worldbank.org.
- Kamaldeen A, Buhari AM, Parakoyi DB (2012) Perception, attitude and practices of parents in Okene, Nigeria towards girls-child education. *International Journal of Scientific and Research Publication* 2 (8) August, 1-7.
- Kandala NN, Kandala SN (2013) The spatial distribution of female genital mutilation (FGM) in Nigeria. University of Warwick, UK.
- Kumar V, Mohanty S, Kumar A, Misra RP, Santoshan M, Awasthi S et al. (2008) Effect of community-based behaviour change management on neonatal mortality in Shivgarh, Uttar Pradesh, India: A cluster-randomised controlled trial. *Landcet* Sept. 27:372 (9644),1151-1162.
- Liang J, Li X, Dai L, Zeng W, Li Q, Li M, Zhou R, He C, Wang Y, Zhu J (2012) The changes in maternal mortality in 1000 counties in Mid-Western China by a Government-Initiated Intervention. *Plos one* 7 (5), 1-9.
- Majali V (2012) The socio-cultural factors affecting the participation of women in agricultural development: Khezana Village in Alice District. (Master thesis). University of Fort Hare.
- Matsumura M, Gubhaju B (2001) Women’s status household structure and the Utilisation of Maternal Health Services in Nepal. *Asia-Pacific Population Journal* 16 (1), 23-44.
- Mekonnen Y, Mekonnen A (2003) Factors influencing the use of maternal healthcare services in Ethiopia. *J HEALTH POPUL NUTR, Centre for Health and Population Research* 1 (4), 374-382.
- National Population Commission [Nigeria] (2008) Nigeria Demographic and Health Survey, NDHS, 2008. Abuja Nigeria, ICF Macro 2009 Calverton, Maryland, USA.
- NAS-The Nigerian Academy of Science (2009) Reducing child mortality in Nigeria. In: Olumide YM, Odunbanjo MO (eds) *Workshop Summary February, 2009*. West African Books Publishers Limited, Lagos-Nigeria.

- Nayak MG, Sharada, George A (2012) Socio-cultural perspectives on Health and Illness. *Nitte University Journal of Health Sciences- NUJHS* 2 (3) September, 61-67
- Olusegun OL, Ibe RT, Micheal IK (2012) Curbing maternal and child mortality: The Nigerian experience. *International Journal of Nursing and Midwifery* 4 (3), 33-39
- Pallikadavath S, Foss M, Stones RW (2004) Antenatal care: Provision and inequality in Rural North India. *Social Science and Medicine* 59 (6), 1147-1158.
- Pathfinder International (2013) Reproductive health knowledge and practices in northern Nigeria: Challenging misconceptions, the reproductive health/family planning service delivery project in Northern Nigeria Funds from David and Lucile Packard Foundation.
- Shamaki MA (2005) Spatial manifestation of urban poverty in Sokoto Metropolis (MSc Dissertation). Department of Geography, Usmanu Danfodiyo University, Sokoto-Nigeria.
- Shamaki MA, Rostam K (2013) Factors affecting maternal mortality in Sokoto State, Nigeria. *Geografi* 1 (2), October. ISSN 2289-4470. Penerbit Universiti Pendidikan Sultan Idris.
- Sokoto State Government-SSG (2012) Sokoto State Ministry of Budget and Economic Planning Project Coordinating Unit. Proposal for 2012 MDG Conditional Grants Scheme (2012 CGS/SSG Sokoto).
- TSHIP (2010) Targeted states high impact project. Advancing health in Bauchi and Sokoto States. Annual Report. TSHIP Central Project Office. October 1, 2009-September 30, 2010. Support From USAID
- United Nation Population Funds-UNFPA (1998) Socio-cultural factors affecting attitude and behaviour regarding population and family life issue in Nigeria. In: Akinfeleye R, Charles JO, Omideyi AK (eds) Lagos, Nigeria.