Socio-cultural Factors Associated with Maternal Mortality in Nigeria

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Abstract: The paper examines the socio-cultural factors associated with maternal mortality and morbidity particularly in rural Nigeria. Using the gender perspective the paper explains how gender relations, poverty and other socio-cultural factors relate to maternal mortality and the possible effects of this relationship on food security and well-being in the household. The paper argues that socio-economic and cultural factors and indeed gender discrimination contribute to high maternal mortality and morbidity in rural Nigeria. The paper explains that the Millennium Development mandate to developing countries to reduce maternal deaths by a minimum of 75% by 2015 cannot be attained without identifying and addressing these cultural issues.

Key words: Mortality, socio-cultural, maternal, factors, Nigeria.

INTRODUCTION

With only two percent of the world’s population, Nigeria contributes ten percent of the world’s maternal death[2]. Each year as many as 60,000 Nigerian women die due to pregnancy related complications[14]. Globally only India has a larger number of maternal deaths from pregnancy-related complications as many as 136,000 annually[20].

Nigeria is by tradition a patriarchal society in which women are discriminated against from infancy. In the rural setting, gender disparity has been observed with women generally receiving less attention than men. Poorer access to medical services is compounded by social, cultural and economic factors including gender inequality in access to food, by burden of work and by special dietary requirements such as iron supplements. This is why many women and particularly rural women are often trapped in a cycle of ill-health exacerbated by child bearing and hard physical labour. Seclusion for example was found to have a compounding effect on the high maternal mortality of 1000 deaths per 100,000 live births among Hausa women in Northern Nigeria[18].

One important and significant international response to the UN Decade for Women was the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). The convention identifies women’s rights as human rights and demands their inclusion in all spheres of national life. Nigeria ratified CEDAW in 1985, but while the provisions of the treaty enjoy international law, they are not yet part of Nigeria’s domestic framework. Although the convention is not legally enforceable in domestic legislature, by nature of the ratification Nigeria has accepted the obligation to be assessed in terms of its respect for the rights of women and also in terms of its progress since ratification[9]. In response to UN initiations, Nigeria formulated and approved a National policy on women. The policy is an attempt to incorporate women fully into national development as equal partners, decision makers and beneficiaries of Nigeria, through the removal of Gender based inequalities[7]. The policy aspires to include women in all spheres of national life, including education, science and technology, healthcare, employment, agriculture and industry, environment, Legal justice, social services and the media. It aspires to eliminate the negative aspects of Nigerian culture which serve only to harm women. Finally it also challenged the patriarchal status quo. However, tangible evidence of any improvement particularly in the status of rural women is slow to appear.

Despite the fact that women in Nigeria produce most of the nation’s food (some 60 ~ 80% of the labour input in African agriculture[1] and are responsible for the survival of their family, they are inadequately recognized or rewarded for their efforts. They experience social exclusion and violations of their human, civil, legal and reproductive rights. In terms of their reproductive role, women suffer discrimination and marginalization through denial of rights to land ownership and access to credits facilities and inputs. In practical terms, this is reflected in adverse social and
health statistics revealed in the maternal mortality and morbidity rates, 1,100/100,000 live births[21] and also reflected in their limited access to educational and employment opportunities.

Nigerian women are indeed in an important position to contribute to food security, nutrition and overall health status of the family and the community at large. Given that women constitute more than half of the country’s population, setting policies which are gender-sensitive, inclusive and empowering will reduce the rate of maternal mortality and improve the Human Development Index which will also have a powerful impact on poverty alleviation.

The objective of this paper is to discuss the socio-cultural factors associated with maternal deaths in rural Nigeria and suggest ways of improving on and eliminating these factors.

Methodology: The methodological approach to this paper was based on reviews of multiple documents including demographic and other surveys, government policy documents, health reports and safe motherhood guidelines, documents from bilateral and multilateral donors, national government and development plans, published research on Nigeria safe motherhood and maternal mortality as well as field interviews in the rural areas.

Maternal Mortality: Maternal mortality refers to the death of a woman while pregnant or within forty–two days after delivery or termination of pregnancy, excluding accidental causes of death (WHO). For each woman who succumbs to maternal death, many more will suffer injuries, infections and disabilities brought about by pregnancy or childbirth complications such as obstetric fistula. This is commonly known as vesicovaginal fistula (VVF), a hole in the birth canal that allows leakage from the bladder or rectum into the vagina which is a major complication from pregnancy and childbirth[10]. This is usually a problem of young girls who marry early, often before the age of fifteen and who start childbearing before their bodies are ready for that function. Both maternal mortality and morbidity are closely associated with patterns of gender relations and poverty situations in any given society. Such associations are more pronounced in the rural communities where traditional attitudes and norms conform to patriarchal values which support males’ superiority over females[3].

There is no single cause of death and disability for men between 15 and 44 that is close to this magnitude. No other area of health so clearly demonstrates the impacts of gender inequality on women’s live. One of the cardinal objectives of the Millennium Development Goals (MDGs) was to mitigate the rising profile of maternal mortality rate by 75% by 2015. Deaths from common medical causes of maternal deaths such as hæmorrhage, toxaemia, infection, obstructed labour and unsafe abortion can be prevented if properly and effectively managed.

In sub-Sahara Africa and Nigeria in particular the increase in the rates of maternal mortality is not only due to inadequate health services; none medical factors such as socio-cultural practices have turned out to be intractable problems even in situations where modern health-care facilities and personnel are available. The consequences of maternal mortality and morbidity are felt not only by women but also by their families and communities. Women are primary guardians of the health, education, nutrition and social well-being of their children and in many cases breadwinners of the family which makes the impact of maternal mortality in affected families traumatic. Maternal deaths perpetuate poverty in the family and represent a loss of potential income and increasing socio-economic burden on the family.

Effort to reduce maternal mortality and morbidity must therefore address the socio-cultural factors that impact women’s health. Women’s low status in the society, lack of access to and control over resources, limited educational opportunities, poor nutrition and lack of decision making power should be seen as both ethic obligation and collective responsibility for national development.

The Gender Perspective: The gender perspective as discussed during the 1997 NGO symposium on Health for all women and men, looks at how,……. socially constructed roles and relationships have direct bearing on the health and well being of both sexes. A gender perspective helps identify the inequalities between women and men, which in the field of health can lead to both increased illness and death from preventable causes. A gender approach to health examines how gender differences determine access to benefits and the way in which technology; information, resources and healthcare are distributed. It provides the foundation for maximizing human resources in development because the result of equal access to resource benefits and opportunity to all…………will be a more enlightened, educated, healthy and independent society[8].

The Gender Dimension of Maternal Mortality: The Rural Setting: Findings from several studies that have attempted to determine maternal death rates in Nigeria, uniformly show high national levels, large urban–rural disparities and wide variations across geographic regions with maternal mortality particularly severe in the country’s predominantly Islamic northern states[15]. A 1997 Multiple Indicator Cluster Survey

Food Restrictions and Taboos:

Maternal Mortality:
Cultural and Ritual Practices That Sustain High morbidity women experience in the rural areas factors help to explain the high maternal mortality or impoverish women’s health. She maintains that these bearing and physical agricultural work combine to working in the field. She noted that frequent child care, domestic duties, fetching water and to include serving male members and children. These highlights one of the cultural requirements of women involving strenuous physical labour that could be injurious to them. For women who are already malnourished and suffering from iron deficiency anaemia, their pregnancy state and child delivery could become extremely hazardous.

Linkage with Agriculture: Men and women engage in different agricultural activities with different impacts on their health. Women tend to be involved in those aspects which involve strenuous physical labour that would have disastrous effects for pregnant women, such as stooping to weed. Also work in the farm often involves carrying loads that may be inappropriate for pregnant or under-age women, as well as adopting working postures that could be injurious to them. For women who are already malnourished and suffering from iron deficiency anaemia, their pregnancy state and child delivery could become extremely hazardous.

Boserup[4] discussing women and development, highlights one of the cultural requirements of women to include serving male members and children. These involve child care, domestic duties, fetching water and wood, processing crops, tending small animals and working in the field. She noted that frequent child bearing and physical agricultural work combine to impoverish women’s health. She maintains that these factors help to explain the high maternal mortality or morbidity women experience in the rural areas

Cultural and Ritual Practices That Sustain High Maternal Mortality:
Food Restrictions and Taboos: Food restrictions and taboos constitute a major area of cultural impact that creates problems for pregnant women. In some rural societies women eat food after men. Depending on the quantity and quality of food available, a pregnant woman who eats left-overs may also lack sufficient nutrition. Severe anaemia plays a part in up to 40 per cent of the estimated 600,000 maternal deaths each year in the developing world (UNFPA). In southern Nigeria pregnant women are not encouraged to eat snails, which are rich in calcium, to avoid their babies drooling[13]. Denial or avoidance of such foods can adversely affect the health of pregnant women by increasing their chances of suffering from anaemia. Cultural beliefs, practices and taboos organized according to mainstream societal values dominated by patriarchal values of male superiority and preference exacerbate difficulties of pregnancy and childbirth often leading to maternal mortality or morbidity.

Childhood Marriage: Early age at marriage as a demographic as well as cultural, compounds reproductive health of women by introducing long period of exposure to pregnancy. A UNICEF/FGN assessment reports that “culturally-based limitations on the exercise of women’s reproductive rights are among the key factors underlying the high levels of maternal, infant and under-five mortality[9]. In Nigeria it is common practice for parents to arrange the marriage of their young daughters, particularly to older men. Marrying out children of ten to fifteen years is premised on the value to protect them from falling victim to teenage pregnancy. In the north for example, 26.5 per cent of marriages are characterized by age difference of 15 years or more between husband and wife[9]. Statistics show that 24.4 per cent of girls between the ages of 15 and 19 are married, while the figure for boys of the same age is just 2.2 per cent. The figures for ages 20-24 show that 57.6 per cent of women are married, while only 14.2 per cent of men in the same age group are married. Men marry later than women: their median age at first marriage is 26 years, compared with 18 years for women[11].

In Nigeria age of marriage and of sexual activity is largely culturally determined. In the northern states, the average age is 15 years, whereas in the south it is 18 and 20 years. Section 18 of the marriage Act at the Federal level recognizes a person under 21 years of age as a minor, but allows minors to marry with parental consent.

Childhood marriage has many implications. It robs girls of power over their bodies and their freedom to make decisions about their own reproductive health. Early childbirth has negative demographic, socio-economic and socio-cultural consequences[13]. It compounds the general inability of girls and women to

(MICS) estimated a maternal mortality ratio (MMR) of 704 deaths per 100,000 live births for a period of six to twelve years preceding the survey (FOS &UNICEF 2000). It found a significantly higher rural than urban MMR (828 versus 531), and considerable variance across regions, ranging from 165 in the southwest to 1549 in the northeast.

Nevertheless in rural settings of developing countries, gender disparity has been observed in healthcare with women generally receiving less attention than men. In rural India for example, the World Bank[19] reported that “females experience more episodes of illness than males and are less likely to receive medical treatment before the illness is well advanced.” India and Nigeria are two countries with large rural populations; 73.9 and 59.5 per cent respectively and which have seriously underserviced rural communities[19]. Patriarchal values predominate implying the existence of big gender disparities. It is no wonder that adverse maternal health conditions are exaggerated for their rural women. The United Nations (1999) draws attention to the convention of the Elimination of All forms of Discrimination Against Women (CEDAW’s) stipulation that “Obligates States Parties to take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families.....”
Female Genital Mutilation: Female Genital Mutilation (FGM), commonly known as Female Circumcision involves the cutting off of part or whole of a girl’s clitoris and some other parts of her sex organs for cultural or any other non-therapeutic reasons. The WHO Technical Committee in 1995 classified female genital mutilation into four main categories namely:

Type I – Excision of the prepuce (the fold of skin above the clitoris) with or without excision of part or all of the clitoris. (This is referred to as “Sunna”)

Type II – Excision of the prepuce and clitoris (clitoridectomy) together with partial or total excision of the labia minor (inner lip).

Type III – Excision of part or all of the external genitalia and stitching/narrowing of the vagina opening (infibulation).

Type IV – Unclassified: includes pricking, piercing, or incision of the clitoris and/or labia cauterization by burning of the clitoris and surrounding tissue, scraping of tissues surrounding the vaginal wall (gishiri cuts); introduction of corrosive substances into the vagina with the aim of tightening or narrowing it. The procedures described above are irreversible and their effects last a lifetime. The reasons given to justify FGM include custom and tradition, purification, family honour, hygiene, aesthetic reasons, protection of virginity and preventing promiscuity.

The practice of FGM is wide spread in Nigeria and varies from one state and cultural setting to another. In some cultures it is carried out at infancy or childhood as a “rite of passage” to adulthood. In some other it is at first pregnancy and in some at death. National data on the extent of the practice in Nigeria are scarce, although for the first time the topic was included in the 1999 NDHS. The UNICEF/FGN situation assessment reported that given the size of Nigeria’s population, Nigerian women constituted one quarter of the 115 – 130 million circumcised women throughout the world – the highest number of cases in absolute terms in the whole world. According to NDHS[12], the prevalence rate by zone is as follows: South-west 56.9%, South-south 34.7%, South-east 40.8%, North-west 0.4%, North-east 1.3% and North-central 9.6%. Infibulation the most extreme form of mutilation is conducted in the north, which accounts for 10 % of all FGM practiced in Nigeria[17].

FGM can be considered vital in maintaining the high numbers of maternal mortality in Nigeria as it is a major risk factor for obstructed labour. A recent study by WHO[21] has shown that women who have had FGM are significantly more likely to experience difficulties during childbirth and that their babies are more likely to die as a result of the practice. Serious complications during childbirth include the need to have a Caesarean section, dangerously heavy bleeding after the birth of the baby and prolonged hospitalization following birth. The study showed that the degree of complications increases according to the extent and severity of FGM. Although the practice is globally and nationally prohibited, there is no legislation for effective discontinuation in Nigeria. Recently State laws banning of FGM have been introduced in Cross River, Delta, Edo and Ogun States, with similar laws under consideration in Akwa-Ibom and Bayelsa[17]. The national policy on women recognizes the harmful effects of FGM and other such practices and recommends that the “government should legislate the mandatory provision of maternal health services……. to all women to protect them from such disabilities as vesico-vaginal fistula (VVF), FGM and other harmful traditional practices (Federal Ministry of Women Affairs and Youth Development 2000).

Religion: Religious factors also affect maternal mortality in a large scale. Religion is a problem not only due to its effect on women’s societal position but also because of harmful beliefs and traditions relating to childbirth. The Islamic custom of Purdah – the seclusion of women from the sight of men is practiced in Nigeria. Purdah generally applies to married women and girls who have reached puberty; although the
practice varies from country to country and region to region. Purdah takes various forms but in essence it prohibits women from interaction with strangers inside and outside the home. The women are required to ask for their husbands’ permission when they need to seek medical assistance. Although evidence suggests that the practice in its most fundamental form has declined, it nonetheless exists and is being re-introduced under Sharia law in various states in the north. The practice deprives women of their rights to freedom of movement and association, and their access to education and other social services, it impedes their contribution to family income and their ability to care for their families, it excludes them from participation in the wider society, thus adding to their poverty. Church also is a favoured place for delivery as it is believed that the holy setting will protect both the mother and the child from malicious spirits and witchcraft. Up to 50% of health care services are provided by religious organizations and in case of delivery, most of the childbirth are attended without any skilled personnel. Also certain religions do not encourage blood transfusion and this most times leads to the death of some women after childbirth.

**Conclusion:** The view has been expressed that patriarchal institutions, values and attitudes marginalize women vis-à-vis men in the legal systems, in decision making powers, in education and employment thereby limiting their effective use of available resources to improve their health. Lifetime denials, subordination, marginalization and poverty result in ill health or emergency health complications in pregnancy and childbirth. The cumulative effects are high maternal mortality and morbidity in the developing countries. Using the gender analytical approach has assisted in drawing attention to the multidimensionality of the problem of maternal mortality that requires partnership of many stakeholders in its solution; The nature of the problems identified and highlighted show that interventions aimed at reducing maternal mortality and morbidity will entail extensive community education. Also a thorough understanding of existing knowledge, beliefs, attitudes and practices is very necessary.

**REFERENCES**

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