IMPACT OF SOCIOCULTURAL BELIEFS ON MATERNAL HEALTH-SEEKING BEHAVIOR AMONG WOMEN OF REPRODUCTIVE AGE IN ZAMFARA STATE

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Abstract

Maternal health outcomes in Nigeria remain among the poorest globally, particularly in northern states such as Zamfara, with socio-cultural factors playing pivotal roles in influencing women's health-seeking behavior. This study explored how cultural norms, religious beliefs, gender roles, and traditional healthcare systems affect the utilization of maternal health services among women of reproductive age in Zamfara State. Employing a mixed-methods design, data were collected from 150 women through surveys and 12 Focus Group Discussion (FGD) sessions across three local government areas: Gusau, Kaura Namoda, and Anka. The findings revealed that early marriage, low level of women's autonomy, practice of spiritual healing, reliance on traditional birth attendants, and minimal male involvement, pose significant obstacles to accessing antenatal and skilled birth care. Even though there is an awareness of the advantages of formal healthcare, cultural preferences, financial limitations, and interpretations of religious beliefs affect women's choices. The study recommends culturally sensitive health interventions, community engagement, and policy reforms to enhance maternal healthcare utilization.

Keywords: Health-seeking behaviour; Gender roles; Maternal health; Sociocultural beliefs; Traditional Birth Attendants

Introduction

Nigeria plays a significant role in global maternal mortality, contributing to nearly 20% of maternal deaths worldwide (World Health Organisation, 2023). In northern Nigeria, particularly in Zamfara State, maternal health indicators are extremely poor (high rate of home deliveries, limited use of skilled birth attendants, and inadequate access to postnatal care within 48 hours after delivery), largely due to deeply rooted sociocultural norms that obstruct women's access to skilled care (Opara, Iheanacho, and Petrucka, 2024). The relationship between cultural beliefs, religious ideologies, gender roles, and health-seeking behaviour requires academic investigation to inform targeted strategies (Adetoro, Adegoke, and Adedokun, 2016).

Maternal health-seeking behaviour refers to a woman's actions in recognizing and addressing health needs throughout pregnancy, childbirth, and the postpartum phase (Magaji, Bello, and Yusuf, 2018). It is essential to understand how sociocultural factors influence this behaviour, especially in traditional, conservative communities like those in Zamfara. This study examines the socio-cultural factors affecting maternal health-seeking behaviour among women in Zamfara State, Nigeria. Early marriage, common in northern Nigeria, reduces women's educational attainment and autonomy, both of which are strongly correlated with lower health service utilization (United Nations Children's Fund UNICEF, 2021).

Religious teachings significantly affect maternal care decisions. While Islam encourages seeking medical care, local interpretations often emphasize divine will over medical intervention, leading many women to priorities prayers or spiritual rituals over hospital visits (Abor, Abekah-Nkrumah, Sakyi, Adjasi, and Abor, 2009). This religious fatalism contributes to delays in seeking skilled birth attendance.

Gender norms in patriarchal societies place men in decision-making positions, often requiring women to seek their husbands' permission before visiting health facilities (Shamah-Bright, Uchendu, Jalo, Danlamin, Ogunlayi, 2022). In some cases, male disapproval, mistrust of male doctors, or financial constraints lead to the abandonment of formal healthcare services (Afful-Mensah, Osei, and Asiedu, 2014).

Traditional birth attendants (TBAs) play a central role in many rural communities. Their cultural familiarity, accessibility, and affordability make them the preferred choice for childbirth despite evidence linking unskilled attendance to poor maternal outcomes

(Ogunyemi & Odusanya, 2005). In Nigeria, cultural perceptions about childbirth being a natural, private event often dissuade women from seeking skilled care (Dada, 2018). According to Kea, Tulloch, Theobald, and Kok **(**2018), TBAs often bridge the cultural gap between local beliefs and health systems. Health system-related barriers, including poor infrastructure, lack of female healthcare providers, distance to clinics, and disrespectful provider behaviour, further discourage women from seeking care (Bohren, Hunter, Munthe-Kaas, Souza, Vogel, Gulmezoglu, Tunçalp, 2017). Additionally, shame, shyness, or the stigma of exposing one's body to a male healthcare worker contribute to low facility births (Ogundairo & Jegede, 2016).

Efforts to improve maternal health outcomes must therefore go beyond biomedical approaches. A culturally competent healthcare system, community engagement, gender equality, and integration of TBAs into formal systems have all been recommended as effective interventions (Kifle, Azale, Gelaw, Melsew, 2017; Opara et al., 2024). This paper explores impact of sociocultural beliefs on maternal health-seeking behavior among women of reproductive age in Zamfara State.

Theoretical Framework

The Health Belief Model (HBM) serves as the framework for this study, providing insights into individual perceptions and factors that affect health behaviour. According to the HBM, behaviour is shaped by perceived susceptibility, perceived severity, perceived benefits, and perceived barriers, along with cues to action and self-efficacy (Rosenstock, 1974). These elements help to illuminate the psychological and sociocultural factors that impact women's decisions. HBM constructs include perceived barriers (such as cultural norms and male authority), perceived susceptibility (underestimating the risk associated with home births), and cues to action (like guidance from religious leaders or media initiatives) surfaced as prominent themes. Examining maternal health behaviour through the Health Belief Model aids in understanding why some women postpone or reject formal healthcare despite being aware of its advantages.

Methodology

A convergent mixed-methods approach was adopted to capture both the breadth and depth of maternal health-seeking behaviour. Quantitative and qualitative data were collected concurrently and analysed separately before integration.

The study was conducted in three Local Government Areas (LGAs) in Zamfara State: Gusau, Kaura Namoda, and Anka. These areas were selected due to their ethnic diversity, health service distribution, and high maternal mortality prevalence.

The target population comprised women aged 18–49 who were pregnant or had delivered within the last two years. A total of 150 women were selected using a combination of purposive and snowball sampling to ensure representation of different marital, educational, and religious backgrounds. Structured questionnaire was used to gather data on demographics, health-seeking behaviour, and service utilisation while 12 Focus Group Discussion (FGD) sessions were held with different community stakeholders among them, women, traditional birth attendants, male spouses, and healthcare workers. Discussions explored cultural beliefs, religious practices, and gender norms related to maternal care.

Quantitative data were processed and analysed using SPSS version 26 to generate descriptive statistics and identify patterns while audio recordings were transcribed, coded, and analysed thematically. Emerging themes from the date were aligned with the HBM constructs. Ethical clearance was obtained from the Zamfara State Health Research Ethics Committee, Ministry of Health, on behalf of the Author's organisation of affiliation, Lonibu Health Development Foundation, on 08th September, 2023.

Results

Table 1: Socio-Demographic Characteristics of Respondents (N = 150)

Variable	Category	Frequency (n)	Percentage (%)
Age Group (years)	18–24	40	26.7%
	25–34	67	44.7%
	35–49	43	28.6%
Marital Status	Married	142	94.7%
	Single/Divorced/Widowed	8	5.3%
Age at Marriage	Below 18 years	113	75.3%
	18 years and above	37	24.7%
Educational Level	No formal education	96	64.0%
	Primary	28	18.7%
	Secondary	18	12.0%
	Tertiary	8	5.3%

Variable	Category	Frequency (n)	Percentage (%)
Religion	Islam	146	97.3%
	Christianity/Other	4	2.7%

Source: Field Survey, 2024

As shown in table 1, the majority of the respondents (44.7%) were aged between 25–34 years, with an additional 26.7% aged 18–24. A significant proportion (75.3%) got married before the age of 18, and 64.0% had no formal education. Most participants (97.3%) were Muslim, and 94.7% were currently married.

Table 2: Maternal Health-Seeking Behaviours and Influencing Factors (N = 150)

Health-Seeking Indicator	Category	Frequency (n)	Percentage (%)
Antenatal Care Attendance (last pregnancy)	Yes	86	57.3%
	No	64	42.7%
Place of Last Delivery	Health facility	63	42.0%
	Home/TBA	87	58.0%
Permission Needed to Seek Care	Yes	101	67.3%
	No	49	32.7%
Use of Traditional Remedies During Pregnancy	Yes	109	72.7%
	No	41	27.3%
Belief in Spiritual Protection Over Medical Care	Agree	91	60.7%
	Disagree	59	39.3%

Source: Field Survey, 2024

Table 2 shows that only 57.3% of respondents attended antenatal care during their most recent pregnancy, while 58.0% delivered at home or with a traditional birth attendant. Two-thirds (67.3%) of women reported needing spousal permission to access healthcare services. Additionally, 72.7% used traditional remedies during pregnancy and after delivery, and 60.7% believed in spiritual protection as an alternative to medical care.

Disaggregated data from Focus Group Discussions (FGDs) revealed that early marriage was widely accepted and often led to early pregnancies, with limited knowledge of maternal health. Herbal remedies were the first line of treatment for symptoms, and many believed complications could be spiritually addressed. TBAs were widely trusted, seen as culturally aligned, and more spiritually grounded than health worker.

Furthermore, Islamic teachings were interpreted in ways that either supported or discouraged clinical visits. While some imams encouraged facility-based care, others emphasised that childbirth outcomes were preordained. Practices such as Rubutu (spiritual water) were commonly used alongside or in place of clinical services.

Participants often cited the need for male approval before accessing health services. Male spouses expressed concerns about finances, exposure of wives to male staff, and cultural expectations. This control contributed to delays in or rejection of formal healthcare.

Respondents described healthcare facilities as distant, overcrowded, and often lacking in respectful treatment. Women shared that nurses were perceived as rude or judgmental. As a result, many preferred to deliver at home with TBAs, whom they found to be more empathetic and accessible**.**

Discussion

This research reaffirms previous findings that sociocultural and religious factors play a crucial role in influencing maternal health-seeking behaviours in northern Nigeria. Of the 150 women surveyed, 75.3% were married before turning 18, and 64.0% lacked formal education, which limits their independence and access to skilled healthcare. Additionally, 67.3% needed permission from their spouses to seek medical assistance, while 72.7% depended on traditional remedies, demonstrating a strong commitment to cultural practices and limited decision-making authority.

Although more than half of the respondents attended antenatal care (57.3%), the preference for home births (58.0%) and traditional birth attendants indicates a gap between knowledge of biomedical services and their actual use. These behaviours suggest a low perceived susceptibility of complications and significant perceived barriers; two important elements of the Health Belief Model (HBM). Religious interpretations also play a role in this pattern: 60.7% of women preferred seeking spiritual protection rather than clinical care, which aligns with studies indicating that faith-based fatalism hinders formal health-seeking.

Traditional birth attendants are deeply woven into maternal care systems, serving not just as cultural symbols but also as accessible and trusted healthcare providers. Incorporating TBAs into the formal health system by offering training and establishing referral pathways could help align traditions with safe practices. Likewise, involving men as partners in

maternal health through focused education and community discussions may help tackle permission-related delays and foster collaborative decision-making.

Ultimately, systemic enhancements are vital. Reports of disrespectful treatment and a lack of female healthcare providers contribute to the reluctance to use clinical services. Improving respectful maternity care, increasing the availability of female healthcare workers, and decentralising services to lessen travel challenges could greatly enhance maternal health outcomes.

Conclusion

Maternal health-seeking behaviours in Zamfara are influenced by cultural, religious, gender-related, and systemic factors, including early marriage, low women's autonomy, practices of spiritual healing, reliance on traditional birth attendants, and minimal male involvement. To tackle maternal mortality effectively, it is essential to implement localized interventions that are sensitive to the culture and operate within these established frameworks. Enhancing women's empowerment, educating men, engaging traditional birth attendants (TBAs), and reforming the healthcare system can collectively improve maternal health outcomes in the area.

Recommendations

i. **Culturally Sensitive Campaigns**: Government health education initiatives must engage religious and traditional leaders to reinterpret and challenge harmful cultural beliefs.
ii. **Male Involvement**: Couple-focused reproductive health programs promoting spousal support and male participation in maternal health can enhance decision-making.
iii. **Community-Based Interventions**: Employing and training TBAs in safe delivery and referral practices can bridge cultural gaps in the study area.
iv. **Health System Strengthening**: Improving clinic accessibility, staff attitudes and female-provider availability is essential to mitigating the factors identified to negatively impact maternal health-seeking behavior among women of reproductive age in Zamfara State.

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