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Full Length Research

Influence of Cultural Practices on Maternal Morbidity and Complications in Katsina-Ala Local Government Area of Benue State, Nigeria

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The role of culture is apparent and uncompromising, such as women obtaining permission from their husbands before accepting or adopting any contraceptive method. Unfortunately, these patriarchal systems are still maintained in Katsina-Ala, to subjugate women and render them vulnerable to obnoxious cultural practices, which violate the rights of girls or women. Women are arbitrarily deprived of their liberty to express and exercise their fundamental rights. In spite of the high risk of maternal morbidity or too closely spaced birth; women often cannot exercise control over their own fertility. Hence, this study examined the influence of cultural practices on maternal morbidity and complications in Katsina-Ala Local Government Area of Benue State. The study adopted positivist and constructivist design approach of data generation and analysis using Survey and Interpretative Phenomenological Analysis (IPA) methods. Theoretically, Radical Feminism Theory (RFT) was employed in the study. Based on the findings, the study attested that 35.1% of women in Katsina-Ala local government normally get married at the age of 16-20 when most of their systems are not yet developed thereby causing sickness like Vesico-Vagina Fistula (VVF). The findings revealed that 51.4% of the women in Katsina-Ala local government have given birth to children at home. Also, the use of herbal treatment during pregnancy instead of seeking proper medical attention from a medical practitioner constitutes another reason for such complications. Conclusively, infection is another reason that women get infected with diseases as a result of poor medical treatment.

Keywords: Benue State, complications, cultural practices, Katsina-Ala and maternal morbidity.

INTRODUCTION

Majority of maternal health challenges facing Benue State and particularly Katsina-Ala are the dominance of cultural practices arising from women in different ethnic groups in the state. Complications during pregnancy and childbirth are the leading causes of disability and death among women of reproductive age in Katsina-Ala. UNFPA (2017) discovered that for every woman who dies of pregnancy-related causes, 30 to 40 per cent experience acute or chronic morbidity, with permanent sequelae that undermine their normal functioning physically, mentally, sexually, socially and economically, etc. A study by

MICS (2016) revealed that barriers to access health care services normally result from the influence of strong cultural practices existing in Nigeria. Katsina-Ala, one of the Local Government Areas in Benue State, has a consistent maternal morbidity and complications.

The role of culture is apparent and uncompromising, such as women obtaining permission from their husbands before accepting or adopting any contraceptive method. Unfortunately, these old patriarchal systems are still maintained in Katsina-Ala, to subjugate women and render them vulnerable to obnoxious cultural practices, which violate the “rights” of girls or women. Women are arbitrarily deprived of their liberty to express and exercise their fundamental rights. In spite of the high risk of maternal morbidity or too closely spaced birth; women often cannot exercise control over their own fertility. Hence, culture is a barrier and has a compelling nature that regulates all the aspects of human life, which include: food, religion, dressing and language of the people, housing, marriage and family relations (Ibe, 2017).

A report by Nigeria Demographic and Health Survey (2018) revealed that some of the cultural practices that play a key role in preventing women in seeking care that lead to maternal morbidity and complications include low status of women and their participation in decision making. According to the study, 30% of women in Benue State are involved in decision making on their health matters while 60% of women are not involved in any kind of decision in the house especially in regards to health issues. In this context, this study examined cultural practices, which include early marriage, low status of women in decision making and home delivery practices, as barriers in the use of modern maternal health facilities thereby accounting for high maternal morbidity and complications leading to inaction in cases where maternal death could be averted.

Motivation of the Study

In Nigeria, Benue State and Katsina-Ala in particular, women are expected to be submissive, obedient and respectful to their husbands no matter how educated they may appear to be. There is also a belief system in the state that male dominance, render women powerless to boldly make decision relating to their health, while pregnant, except with the permission of their husband, which results in delay that causes complications and morbidity. A husband is regarded as the head of the household and he dictates when the wife is to go for antenatal services as well as to deliver at the hospital or at home, because he is the one to pay the bills. In most cases, the woman has no right to go to the hospital except with the permission of the husband. In situation where the husband is not around, she must await his arrival and this delay could lead to complications and often times, preventable death. This low status of the woman to negotiate conditions favouring her is even made worse if she is an illiterate, poor and rural dweller.

Early marriage and pregnancy among young girls ranging from (15-19 years old), also leads to pregnancy related complications like pelvic disproportion and dislocation resulting from incompatibility of the foetus and the immature pelvis bones, extensive laceration of the reproductive organs, due to the narrow pelvis of these young girls, which often result to fistula and often time still births due to severe haemorrhage resulting from obstructed and prolonged labour. Similarly, Ibe (2017) found that majority of women who deliver outside the health facilities in Bauchi State gave birth at home, where risks of morbidity are on the increase in the absence of professional attendance. According to her, 82.5% of the women in Bauchi State deliver at home. These deliveries are attended by neighbours, traditional birth attendants, auxiliary nurses, midwives and family members, which is influenced by conservativeness among the clan and family elders who tend to force their daughters to practice traditional maternal health practices, like conceiving children using traditional medicines without going to hospital.

Furthermore, some social members and friends also convince pregnant women not to go to the hospital; instead, they stay and bear the children at home so as to reduce costs. However, in the course of pushing a child during birth, these women face the risks of losing their reproductive capacity or even death. A study of this nature was conducted in Bauchi State by Ibe (2017) to ascertain the influence of cultural practices on maternal morbidity and complications. The findings of the study revealed that most women in Toro Local Government Area of Bauchi State gave birth at home and some of them faced complications. This has created a knowledge vacuum in the existing literature in Benue State and Katsina-Ala in particular, which the current study is

replicated and conceived.

Basic Tools of Inquiry

The study was guided by the following research questions:

1. What are the cultural practices that influence maternal morbidity and complications in Katsina-Ala Local Government Area of Benue State?
2. What is the effect of cultural practices on maternal morbidity and complications in Katsina-Ala Local Government Area of Benue State?
3. What strategies can be adopted to eliminate the cultural practices on maternal morbidity and complications in Katsina-Ala Local Government Area of Benue State?

LITERATURE REVIEW

World Health Organisation (1994) defines maternal mortality as a death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and site of the pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. In the contemporary world, maternal mortality is considered a violation of the rights of women and its rate is perceived a critical index of the level of development of a country (Odoi-Agyarko et al., 2006).

Globally, at least 585,000 women die each year from complications of pregnancy and childbirth and almost 90% of these deaths occur in sub-Saharan African. Women in Northern Europe have 1 in 4,000 chance of dying from pregnancy-related causes; for those in Sub-Saharan Africa, the chance is 1 in 16 (Pitterson, 2010). Maternal morbidity refers to the near death of a woman who has survived a complication occurring during pregnancy or childbirth or within 42 days of the termination of pregnancy to non-life-threatening morbidity (WHO, 2011). In developing countries, for every 300 women, about a quarter is victims of maternal morbidity (World Bank, 2007). For every maternal death that occurs, there are approximately 30 more women who would suffer short and long-term disabilities. These include chronic anaemia, infertility, stress incontinence, fistulae, chronic pelvic pain, emotional depression and maternal exhaustion (Odoi-Agyarko et al., 2006).

Maternal Mortality in Nigeria

Nigeria ranks second in the world, after India, in the scale of maternal mortality, with the rate of 500-652 deaths per 100,000 live births (NDHS, 2013). Annually, an estimated 52,900 Nigerian women die from pregnancy related complications out of a total of 529,000 global maternal deaths (WHO, 2008). In Nigeria, a woman's chance of dying from pregnancy and childbirth is 1 in 18, compared to 1 in 4800 in the US (Pitterson, 2010). The maternal mortality rate in Nigeria has wide geographical variation; the highest rates are seen in the North-Central and North-West zones of the country, the lowest rates noticed in the South-West and South- East. According to the survey conducted in February 2010, the record stands at between 165 per 100,000 live births in the South-West and 1,549 per 100,000 live births in the North-East (Onumere, 2010).

It has also been noted that Nigeria is lagging behind in achieving universal coverage of key maternal and health intervention and will unlikely meet the target of the Sustainable Development Goals (SDGs). Nigeria ranks one of the 13 countries in the world with the highest maternal mortality rate and is still not listed among the 10 countries seen to have made rapid progress to meet the goals and it is sad to note that most of the causes of these deaths are either preventable or treatable (Ibe, 2017).

Causes of Maternal Morbidity and Mortality

Maternal death can be caused directly or indirectly. Direct causes, such as severe bleeding, sepsis, eclampsia, obstructed and unsafe abortion account for 50-75% of maternal deaths and the remaining 25-50% is due to indirect causes (WHO, 2004). Indirect causes have been identified as anaemia, malaria, tuberculosis, hepatitis and infections. The indirect causes are the result of a previously existing disease or a disease that developed during pregnancy and was aggravated by physiological effects or complications of childbirth. The cascade of events could be associated with early marriage, lack of child spacing, antenatal care, home delivery practice, hot bath practice, lack or low level of girl child education, socio-economic conditions, accessibility and availability of referral and treatment systems within the health care system.

Empirical Review

Benue Health Fund (2005) found that in some cultures girls are given out in marriage as early as nine years. Before the age of 13 or sooner after commencement of menstruation, they become pregnant. Their ages at the marriage are likely to influence their knowledge of and attitude to maternal complications. Early marriage according to him is regarded as the violation of human rights and is prevalent in Nigeria despite the passage of the Child Rights Act (CRA) of 2003, which abolished the practice. In Nigeria, 43% of girls are married off before their 18th birthday, and 17% are married before they turn 15. The prevalence of child marriage varies widely from one region to another, with figures as high as 76% in the North-Central region and as low as 10% in the South East (UNICEF, 2016). Babalola (2009) found that social restrictions on women prevent them from accessing antenatal and postnatal health care services. He maintained that lack of decision-making power by the women, due to socio-cultural constraints, is pervasive in Nigeria and this affects their ability to take health-care decision for themselves. In Bauchi State for instance, Ibe (2017) found that 56.0% of women are not involved in decisions especially on their health matters. The restrictions mean that women are dependent on the decision of others about medical attention, whether to delay or prevent pregnancy, have antenatal examinations during pregnancy, arrange for skilled delivery attendants, determined the sex and number of children they want and how they want their births spaced.

A report from *The Punch Newspaper* (2017) revealed that some rural dweller in Kaduna State, precisely Kugu in Zaria local government area, urged the state government to plead with their husband, to enable them practice family planning. According to one of the women, Madam Binta Ya'u, said that "many women wanted family planning services but were disallowed by their husbands." Similarly, she said that "many pregnant women are dying before delivery or lose the babies because they got pregnant almost immediately after delivery, when their bodies are not ready for such burden." This is due to the facts that their husbands would not allow them to make decisions on child spacing or family planning practices. Therefore, they are seen as sex machine by their husbands, while their health status is not taken into consideration.

A study by MICS (2016) shows that 82.0 % of women delivered at home and only 16.9% in a health centre. Similarly, a study conducted by Babalola (2009) shows that majority of women who deliver outside the skilled attendants delivered in a separate room or inside the house. Therefore, the percentages of women who had their delivery at home constitute a high percentage, thereby leading to high increase in maternal morbidity. Mojekwu et al., (2005) discovered that accessibility of health services has been shown to be an important determinant of utilisation of health services in developing countries. In most rural areas in Africa, one in three women lived more than five km from the nearest health facility. Thus, the scarcity of vehicles, especially in remote areas and poor road conditions can make it extremely difficult for women to reach even relatively nearby facilities. This prompts women to use traditional medicines and engage in home delivery practices in areas like Katsina-Ala. Again, Addai (2000) found that women in higher socio-economic groups tend to exhibit patterns of more frequent use of maternal health services than women in the lower socio-economic groups. Therefore, poverty is also a prominent reason why pregnant women engage in cultural practices and home delivery practices. A study by World Bank (2002) shows that cultural or traditional conservativeness is another factor that pushes women to depend solely on cultural practices. The cultural perspective on the use of maternal health services suggests that medicine need is determined not only by the presence of physical disease but also by cultural perceptions of illness. In most African rural communities, maternal health services, co-exist with indigenous health care services, therefore, women must choose between the options. The use of modern health services in such context is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of individual women.

Theoretical Framework

The study is anchored on Radical Feminism Theory. Radical feminists assert that society is a patriarchy in which the classes of men are the oppressors of the class of women. They propose that the oppression of women is the most fundamental form of oppression, one that has existed since the inception of humanity. Gender roles and marginalization of women by men are some of the factors resulting to high maternal

complications in our society. Women are subjected to subordination positions in the family and generally in societal issues including government policy-making positions. These women are not free to take decision on issue affecting their well-being especially when it comes to sexual satisfaction and child bearing. Because of this, almost all processes, belief systems and cultural ideas come from men and in favour of men. Women are not only differently situated in society but are also unequal to men. They get less of the material resources, social status, power and opportunities for self-actualization than the men. Women find themselves in the public sphere of education, work, politics and public space as being discriminated, marginalized and harassed by the men. Radical feminist differs in their interpretations of the basis of patriarchy but most agree that it involves the appropriation of women's bodies and sexuality in some form. Shulamith, an early radical feminist writer, argues that men control women's roles in reproduction and child rearing. Because women are biologically able to give birth to children, they become dependent materially on men for protection and livelihood. Radical feminist do not believe that women can be liberated from sexual oppression through reforms or gradual change. They seek to abolish patriarchy by challenging existing social norms and institutions and believe that eliminating patriarchy will liberate everyone from an unjust society. The theory explains that women's position in the society is that of being used, controlled, subjugated and oppressed by men. All these are as a result of patriarchy. Patriarchy in this situation can be seen as a violent practice by men and by male dominated organizations against women (Thompson, 1994). This theory is relevant to this study in the sense that it advocates for an equal opportunities for women and men, that women should receive equal opportunities in all sectors of the society and before the law (Parpart et al., 2000). If such is achieved; a woman can go to the hospital without necessarily awaiting the permission of her husband in the face of pregnancy related complications and for antenatal services. Also, the woman will have the decision power to practice family planning, decide how many children they should have and all these will curb the rate of maternal death.

However, radical feminists take what is known as essentialist position regarding males and females, implying that all women are, by nature, the same. Women are therefore biologically and socially connected, no matter what their social circumstances. If the patriarchal interventions of males could be resisted, then women would be able to coexist in some natural female way. Furthermore, critics argue that, such a conception of patriarchy does not leave room for historical or cultural variations. It also ignores the important influence that race, class or ethnicity may have on the nature of women's subordination. In other words, it is not possible to see patriarchy as a universal phenomenon; doing so risks biological reductionism attributing all the complexities of gender inequality to a simple distinction between men and women.

METHODOLOGY

The study population comprises of all women within the reproductive ages of 15-45, pregnant and married in Katsina-Ala Local Government Area of Benue State. Women were selected for the study because they are likely to have better information on cultural factors leading to maternal death as well as victims of maternal mortality in the study area. Based on the Krejcie and Morgan sample size table in calculating sample size of a population, 250 were selected to represent the entire population of 225,471. Two (2) doctors and two (2) midwives were selected from the General Hospital in Katsina-Ala Local Government including two (2) traditional birth attendants (TBA) in the local government. This makes a total sample of two hundred and fifty six (256) respondents.

The study used Survey and Interpretative Phenomenological Analysis (IPA) methods. The sampling technique used in selecting the respondents is cluster and purposive sampling techniques. The cluster sampling technique was used at the level of identifying the respondents to be administered with the questionnaire. In doing that, two (2) wards out of 11 council wards in Katsina-Ala Local Government was selected using lottery method. In other words, the names of the wards were written in pieces of paper and was folded, shaken and thrown and two (2) wards (Utange and Katsina-Ala Township), were selected, where 40 houses in the two wards were used to generate data. Purposive sampling method was used in selecting the respondents for Interpretative Phenomenological Analysis. General Hospital Katsina-Ala was purposively selected, which two (2) doctors, two (2) nurses and two (2) midwives were selected for the

Table 1. Age of Marriage.

Age of Marriage	Frequency	Percentage (%)
13 – 15	39	15.9
16 – 20	86	35.1
21 – 25	54	22.0
26 above	66	26.9
Total	245	100.0

Table 2. Wives by a Husband.

Wives by a husband	Frequency	Percentage (%)
One	87	36.5
Two	89	36.3
Three	52	21.2
Four	17	6.9
Total	245	100.0

interview, using tape recorder, note book and biro as data gathering instruments. The six respondents were selected based on their working experience, seniority and professionalism.

For survey method, questionnaires, which contained close-ended questions was administered with the aid of two research assistants. Data gathered from the questionnaire was analysed quantitatively using Statistical Package for Social Science (SPSS) software. For qualitative method, interpretative phenomenological analysis was used qualitatively.

RESULTS

A total of 250 copies of questionnaires were administered to respondents in Utange and Katsina-Ala Township. However, only 245 copies, which represent (98%), were retrieved and found usable for the study as the remaining 5 were not returned. The demographic information shows that majority of the respondents were aged from 13 to 26, married, females and has at least secondary school certificate.

Research Question One: what are the cultural practices that influence maternal morbidity and complications in Katsina-Ala Local Government Area of Benue State?

Table 1 shows the responses of age of marriage. The data shows that 15.9% (n=39) are between 13-15% age of marriage; 35.1% (n= 86) of the respondents are between 16-20 age of marriage; 22.0% (n=54) are between 21-25 age of marriage and 26.9% (n=66) of the respondents are 26 above. Based on the data, women between 16-20 ages of marriage constitute the highest number of respondents as shown in the preceding table. The findings of the study are not at significant variance from the findings of the previous studies in the area. Table 2 shows the response of wife or wives per husband. Based on the result obtained from the respondents, 36.5% (n=87) their husbands have one wife. 36.3% (n=89) their husband married two wives. 21.2% (n=52) their husbands have three wives while 6.9% (n=17) their husbands have four wives. The data indicate that most of the wives, their husbands have two wives as shown in the table above. This means that the attention of their husbands will be divided in terms of responsibility.

Table 3 indicates the age of women before having the first child in Katsina-Ala local government. The data point that 19.6% (n= 48) of the respondents are between the age of 13-15 before having the first child; 33.9 (n=83) are between 16-20 of age before having the first child; 31.8% (n=78) are between 21-25 of age before giving birth to the first child and 14.7 (n=36) are between the age of 26 above before giving birth to the first child. Based on the data, most of the respondents give birth to the first child between the ages of 16-20 as shown in the table above.

Table 3. Age before having the First Child.

Age before having the First Child	Frequency	Percentage (%)
13 – 15	48	19.6
16 – 20	83	33.9
21 – 25	78	31.8
26 above	36	14.7
Total	245	100.0

Table 4. Number of Times of Miscarriage.

Number of Miscarriage	Frequency	Percentage (%)
Once	55	22.4
Twice	79	32.2
Thrice	85	34.7
None	26	10.6
Total	245	100.0

Table 5. Number of Children.

Number of Children	Frequency	Percentage (%)
One	65	26.5
Two	94	38.4
Three	53	21.6
Four and above	33	13.5
Total	245	100.0

Research Question Two: what is the effect of cultural practices on maternal morbidity and complications in Katsina-Ala Local Government Area of Benue State?

Table 4 showed the responses of the respondents based on the number of times they have miscarriage. Based on the data, 22.4% (n=55) have miscarriage once; 32.2% (n=79) have miscarriage twice; 34.7% (n=85) have miscarriage three times while 10.6% (n=26) have not experience any miscarriage before. The data indicate that 34.7% record the highest number of women who experience miscarriage in Katsina-Ala local government.

Table 5 showed the responses of the respondents on the number of children. The data indicate that women with a child accounts for 26.5% (n=65); 38.4% (n=94) of the respondents have two children; while 21.6% (n=53) have three children and 13.5% (n=33) have four and above. The result shows that women with two children constitute the highest number of respondents in the study. Based on the result, it is evident that most of them lost their children during child birth.

Table 6 examined the number of women that delivered at home. Based on the data generated, 51.4% (n=126) of the respondents have delivered at home and 48.6% (n=119) have no experience of home delivery as shown in the table above. The data point that most of the women do delivered at home. Based on the result, most of the women in Katsina-Ala local government delivered at home.

Table 7 showed the responses of the respondents regarding complications during delivery at home. Based on the data, 30.6% (n=75) of the respondents agreed that they do face profuse bleeding; 36.3%

Table 6. Delivered at home.

Delivered at home	Frequency	Percentage (%)
Yes	126	51.4
No	119	48.6
Total	245	100.0

Table 7. Complication during delivery at home.

Complication during delivery at home	Frequency	Percentage (%)
Profuse bleeding	75	30.6
Infections	89	36.3
Seizure	46	18.8
Others	35	14.3
Total	245	100.0

Table 8. Antenatal care during Pregnant.

Antenatal care during Pregnant	Frequency	Percentage (%)
Yes	113	46.1
No	132	53.9
Total	245	100.0

Table 9. Practice of family planning by the respondents.

Responses	Frequency	Percentage (%)
Yes	112	45.7
No	133	54.3
Total	245	100.0

(n=89) admit that they do encountered infections while 18.8% (n= 46) face the problem of seizure and 14.3% (n=35) face other complications. Based on the data, women that face the problem of infections constitute the highest number of the respondents in the study; this means that infections are the major issues in Katsina-Ala local government regarding home delivery.

Table 8 showed antenatal care during pregnant. Based on the data, 46.1% (n=113) of the respondents agree that they do go to antenatal care when they are pregnant while 53.9 (n=132) did not go to the antenatal care when they are pregnant. This implies that only 46.1% of women in Katsina-Ala local government normally go to antenatal care during pregnancy as shown in the table above. This means 53.9% of the women do not go to the antenatal during pregnant in Katsina-Ala local government.

Research Question Three: what strategies can be adopted to eliminate the cultural practices on maternal morbidity and complications in Katsina-Ala Local Government Area of Benue State?

Table 9 ascertained the practice of family planning by women in Katsina-Ala local government. Based on the result generated from the respondents, 45.7% (n=112) agree that they do practice family planning while 54.3% (n=133) do not practice family planning. This shows that most of the women in Katsina-Ala local government do not practice family planning. Table 10 showed the practice of hot bath after delivery. Based on the responses, 50.6% (n=124) of the respondents agree that they practice hot bath after delivery while 49.4 (n=121) do not practice hot bath after delivery. The data point that most of the

Table 10. Practice of hot bath after delivery.

Responses	Frequency	Percentage (%)
Yes	124	50.6
No	121	49.4
Total	245	100.0

Table 11. Responses on decision making at home.

Responses	Frequency	Percentage (%)
Yes	99	40.4
No	146	59.6
Total	245	100.0

Table 12. Cultural practices affect the health of women.

Responses	Frequency	Percentage (%)
Yes	163	66.5
No	82	33.5
Total	245	100.0

women in Katsina-Ala local government do practice the hot bath system after delivery.

Table 11 showed the responses on decision making at home. Based on the data, 40.4% (n=99) of the women agree that they make decision at home while 59.6% (n=59.6) of the respondents do not make decision at home. The implication of the findings is that most of the women in Katsina-Ala local government do not make decision at home.

Table 12 examined whether cultural practices affect the health of women in Katsina-Ala local government. Based on the result obtained from the respondents, 66.5 (n=163) agree that cultural practices affect the health of women while 33.5% (n=82) said cultural practices do not affect the health of women. This implies that cultural practices affect the health of women in Katsina-Ala local government.

DISCUSSION

Nzeako (1994) found that in some cultures girls are given out in marriage as early as nine years. Before the age of 13 or sooner after commencement of menstruation, they become pregnant. Their ages at the marriage are likely to influence their knowledge of and attitude to maternal complications. Lule (2005) found that pregnancy related complications are the main causes of deaths for women aged 15-19 worldwide.

Obianyo (2000) states that some other pregnancy related complications like pelvic disproportion and dislocation resulting from incompatibility of the foetus and the immature pelvic bones, extensive laceration of the reproductive organs, the perineum and fistulas (urethral, vagina or recto-vaginal) which is a condition commonly caused by badly-managed labour, thereby leading to obstructed labour, which later becomes complicated with uncontrollable leaking of urine through the vagina.

Osubor et al., (2006) pointed out that traditionally, having many children is a cherished characteristic in many parts of Nigeria and that the women status is often related to the number of children she has and some women derive pride and prestige from their roles as mothers. Many husbands perceive children as signs of their sexual potency and some wives consider bearing children to be their main function. Nigeria Demographic and Health Survey (2013) shows that about 79.3% of women in north-east Nigeria deliver at home. In Bauchi state, the NDHS (2013) reported that only 16.9% of the women deliver at the health facility, the rest 82.0% deliver at home. According to NDHS (2013) some of the reasons given by women for not delivering at the hospital shows that about (1.3%) of their husband did not give them permission to deliver at the hospital, while (5%) says is not culturally right to deliver at the hospital. WHO (2004) also found that maternal death can be caused directly or indirectly. Direct causes such as severe bleeding, sepsis, eclampsia, obstructed and unsafe abortion account for 50-75% of maternal deaths and the remaining 25-50% is due to indirect causes. Indirect causes have been identified as anaemia, malaria, tuberculosis, hepatitis and infections. The indirect causes are the result of a previously existing disease or a disease that developed during pregnancy and was aggravated by physiological effects or complications of childbirth. According to studies supported by MICS (2017) 97.8% of women in Bauchi state are not using any modern method of family planning.

According to Economic Community of Africa (1997)

health of women emanating from some discriminatory harmful cultural practices, especially in developing countries include, early marriage, lack of child spacing (high parity), low level of girl-child education, low status of women, hot bath and home delivery practices, etc. According to Babalola (2009) the social restrictions on women prevent them from accessing antenatal and postnatal health care services. On the whole, lack of decision-making power by the women, due to socio-cultural constraints, is pervasive in Nigeria, and this affects their ability to take health-care decision for themselves.

Pitterson (2010) also established that, globally, at least 585,000 women die each year from complications of pregnancy and childbirth and almost 90% of these deaths occur in sub-Saharan African. Women in northern Europe have 1 in 4,000 chance of dying from pregnancy-related causes; for those in Sub-Saharan Africa, the chance is 1 in 16.

Research question one is an attempt to examine the cultural practices that influence maternal morbidity and complications in Katsina-Ala local government area of Benue State. Among the reasons put forward by the two doctors regarding cultural practices that influence maternal morbidity and complication by women include: early marriage, lack of child spacing, low level of girl-child education, etc. Respondent one admits that they are many cultural practices that led to these complications, but the ones highlighted above are very common. Respondent two also states that low status of women in Katsina-Ala local government can also be seen as another problem that can lead to such complication. WHO (2004) affirm that the cascade of cultural practices could be associated with early marriage, lack of child spacing, antenatal care, home delivery practice, hot bath practice, lack or low level of girl child education, socio-economic conditions, accessibility and availability of referral and treatment systems within the health care system.

Research question two examines the effect of cultural practices on maternal morbidity and complications in Katsina-Ala local government area. Based on the result obtained from the two nurses, they all agree that, some of the effect of cultural practices on maternal morbidity can be attributed to prolong sicknesses. They state that due to cultural practices, so many women get infected to many diseases as a result of prolong sicknesses. Again, most young women die as a result of lack of proper medical attention given to them especially during pregnancy or childbirth. Based on their responses, infection is another reason; they agreed that some women get infected with diseases as a result of lack of proper medical attention. WHO (2008) found that Nigeria ranks second in the world, after India, in the scale of maternal mortality with the rate of 500-652 deaths per 100,000 live birth. That annually, an estimated 52,900 Nigerian women die from pregnancy related complications out of a total of 529,000 global maternal deaths.

Research question three is an attempt to examine some strategies that can be put in place to eliminate the cultural practices on maternal morbidity and complications in Katsina-Ala local government. Based on the data obtained from the midwives, the respondents established that both men and women, especially those who have directly experienced of these harmful cultural practices like early marriage, hot bath and home delivery practices. In order to challenge these cultural practices, women and all stakeholders in one way or the other must recognize the ideology that legitimizes such practices and thus put on a liberated mind to deal with those societal misconceptions about women in Katsina-Ala local government area.

WHO (2004) report revealed that cultural traditions are powerful and only careful efforts will eliminate harmful ones. For example, in the past women groups and human rights activities tackled three (3) harmful cultural practices that have received global scrutiny namely, female genital mutilation, son preference and early marriage. With regard to early marriage which is on the increase in most places in developing world; like in Northern Nigeria, laws outlining minimum age(s) for marriage have been enacted by some countries like Morroco; with reductions in 67 adolescent marriage and according to WHO (2004) the prevalence of early marriage in sub- Saharan Africa and South Asia have remained low. This also validates the assumption of Radical Feminism Theory. Radical feminists maintained that men control women's roles in reproduction and child rearing. Because women are biologically able to give birth to children, they become dependent materially on men for protection and livelihood. Radical feminist do not believe that women can be liberated from sexual oppression through reforms or gradual change. They seek to abolish patriarchy by challenging existing social norms and institutions and believe that eliminating patriarchy will liberate

everyone from an unjust society.

CONCLUSION

Maternal morbidity and complications have become a global issue as a result of loss of many lives. It is on the increase in developing countries, especially countries in the Sub-Saharan region. Countries such as India, Nigeria, etc, have been reported as the leading countries with high rate of maternal morbidity, complications and death. In view of these problems, the findings of the study attest that most women in Katsina-Ala local government normally get married at the age of 16-20 when most of their systems are not yet developed thereby causing sickness like vesico-vagina fistula (VVF). Also, the use of herbal treatment during pregnancy instead of seeking proper medical attention from a medical practitioner constitutes another reason for such complications. Conclusively, infection is considered as another reason that women get infected with diseases as a result of poor medical treatment. The study discovered that most of the women in Katsina-Ala local government give birth to their first child at the age of 16-20. The findings also revealed that most of the women in Katsina-Ala local government area of Benue State have given birth to children at home.

RECOMMENDATIONS

Based on the findings, the study recommends the following:

1. The study recommends that child delivery at home should be abolished; women in Katsina-Ala government should be encouraged by their husband and people in authority so that these women can delivery at the hospital.
2. Women in Katsina-Ala local government should be given enough money by their husband in order to attend proper antenatal care.
3. The replication of the study in different parts of Nigeria and using different methodological and theoretical approaches can enrich the available literature in the area.

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