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CULTURAL PRACTICES AND THEIR INFLUENCE ON MATERNAL HEALTH OUTCOMES IN DASS LOCAL GOVERNMENT AREA, BAUCHI STATE, NIGERIA

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Abstract

This study examined cultural practices and their influence on maternal health outcomes in Dass Local Government Area of Bauchi State, Nigeria. A cross-sectional descriptive survey design was adopted, and data were collected from 384 women of reproductive age (15–49 years) using a structured questionnaire. A multistage sampling technique was employed, while data were analyzed using descriptive statistics and Chi-square test. Findings revealed that several cultural practices remain common in the study area, particularly food taboos, preference for traditional birth attendants, male-dominated decision-making, use of herbal medicine, and childbirth rituals. Overall, these practices were found to significantly influence maternal health behaviour by contributing to delayed access to healthcare, increased reliance on home delivery, and maternal complications. Utilization of maternal healthcare services showed moderate uptake, with about two-thirds of respondents attending antenatal care, while a notable proportion still preferred home delivery. Key barriers to service utilization included distance to health facilities, cost of services, and cultural beliefs. The Chi-square analysis revealed a significant relationship between cultural practices and maternal health service utilization ($\chi^2 = 28.64$, $df = 4$, $p < 0.001$), leading to the rejection of the null hypothesis. The study concludes that cultural practices significantly influence maternal health behaviours and outcomes in Dass LGA despite increasing awareness of modern healthcare services. It recommends community-based health education, male involvement in maternal health decisions, and improved accessibility to health facilities, cost reduction strategies, and integration of traditional birth attendants into the formal health system to improve maternal health outcomes.

Keywords: Cultural Practices, Maternal Health, Antenatal Care, Traditional Birth Attendants, Health Utilization

1. Introduction

Maternal health remains a critical public health challenge in Nigeria, particularly in rural settings where socio-cultural practices strongly shape health behaviours and outcomes. Despite sustained efforts by the Nigerian government and international organisations such as the World Health Organization and United Nations Children's Fund to improve maternal healthcare delivery, the country continues to record one of the highest maternal mortality ratios globally. According to recent estimates, Nigeria accounts for a significant proportion of global maternal deaths, with rural areas bearing a disproportionate burden due to limited access to skilled healthcare services, poverty, and deeply entrenched cultural norms (WHO, 2023; UNICEF, 2024). Cultural beliefs and traditions often influence women's decisions regarding antenatal care, place of delivery, and postpartum practices, thereby directly affecting maternal health outcomes.

In rural communities such as Dass Local Government Area of Bauchi State, socio-cultural practices remain deeply embedded in everyday life and continue to influence maternal health behaviours. Many women rely on Traditional Birth Attendants (TBAs), who are often perceived as more accessible, affordable, and culturally acceptable than formal healthcare providers. Additionally, practices such as food taboos during pregnancy, restrictions on women's mobility, and spiritual interpretations of pregnancy-related complications can hinder timely access to skilled maternal care. While certain cultural practices may offer emotional and social support to pregnant women,

others contribute to delays in seeking appropriate medical intervention, thereby increasing the risk of complications such as haemorrhage, sepsis, and obstructed labour (Okonofua et al., 2018; NPC & ICF, 2019).

Understanding the complex interplay between cultural practices and maternal health outcomes is therefore essential for developing effective and culturally sensitive health interventions. Integrating beneficial traditional practices with modern healthcare services, while addressing harmful beliefs through community-based education and engagement, can significantly improve maternal health outcomes in rural areas. Policymakers and health practitioners must adopt culturally informed strategies that involve community leaders, TBAs, and family members in maternal health programs to ensure acceptance and sustainability. Such an approach aligns with global health priorities advocated by organisations like the World Bank, which emphasise context-specific interventions to reduce maternal mortality and improve reproductive health outcomes in developing countries.

Despite increased awareness of maternal healthcare services, women in Dass Local Government Area continue to experience poor maternal health outcomes, indicating a gap between knowledge and utilisation of skilled care. Socio-cultural practices strongly influence decisions regarding antenatal attendance, place of delivery, and postnatal care, with many women preferring traditional methods and home delivery over formal health services. These choices are often shaped by deeply rooted beliefs, family influence, and trust in Traditional Birth Attendants, which can discourage the use of modern healthcare facilities. The World Health Organization notes that such socio-cultural factors significantly contribute to delays in seeking appropriate maternal care, especially in rural communities (WHO, 2023). As a result, preventable complications during pregnancy and childbirth frequently lead to adverse outcomes, including maternal morbidity and mortality. Practices such as delayed decision-making, reliance on spiritual interpretations, and resistance to medical intervention further increase these risks. According to the United Nations Children's Fund, addressing maternal health challenges in such settings requires a critical understanding of the cultural dynamics that shape health behaviours (UNICEF, 2024). Therefore, examining how cultural practices influence maternal health outcomes in Dass is essential for developing effective and culturally appropriate interventions.

Objectives of the Study

i. To identify cultural practices related to maternal health.

ii. To assess the effects of cultural practices on maternal health outcomes.

iii. To examine utilization of maternal healthcare services.

Research Questions

i. What cultural practices influence maternal health in the study area?

ii. How do cultural practices affect maternal health outcomes?

iii. What is the level of utilization of modern maternal healthcare services?

Research Hypothesis

H_0: Cultural practices have no significant influence on maternal health outcomes.

H_1: Cultural practices have a significant influence on maternal health outcomes.

This study is important for policymakers, healthcare providers, and researchers as it highlights how cultural practices influence maternal health in Dass LGA. For policymakers, the findings provide a basis for developing culturally sensitive policies and targeted interventions that address barriers such as traditional beliefs, cost, and access to healthcare. For healthcare providers, the study emphasizes the need for culturally informed care and community engagement to improve maternal health service utilization. For researchers, it offers valuable data and supports existing theories on

the role of culture and gender in shaping health behaviours, while also serving as a foundation for further studies.

2. Literature Review

This section reviews existing literature on cultural practices and their influence on maternal health outcomes, with particular focus on developing countries such as Nigeria. Maternal health refers to the wellbeing of women during pregnancy, childbirth, and the postpartum period, and it is strongly influenced by social and cultural factors in addition to medical care. Understanding these influences is important for explaining variations in maternal health outcomes across different communities. Cultural practices play a significant role in shaping how women perceive pregnancy and childbirth, as well as the type of care they seek during these periods. In many rural settings, cultural beliefs and traditions influence decisions related to antenatal care attendance, place of delivery, and reliance on traditional birth attendants. These practices can either support or hinder the use of formal healthcare services, depending on the norms and values of the community.

In Nigeria, and particularly in rural areas such as Dass Local Government Area of Bauchi State, maternal healthcare utilization is often affected by deeply rooted cultural beliefs and practices. These practices may contribute to delayed healthcare seeking, reduced use of skilled birth attendants, and preference for home delivery. This review therefore examines relevant studies on cultural practices, maternal health outcomes, and the utilization of maternal healthcare services as they relate to the study area.

Cultural Practices Related to Maternal Health

Cultural practices refer to shared beliefs, values, and behaviours that influence how individuals perceive pregnancy and childbirth. In many African societies, cultural norms strongly shape maternal health decisions, often determining whether women seek formal healthcare or rely on traditional systems. Studies show that in Nigeria, cultural beliefs such as food taboos during pregnancy are widely practiced, where pregnant women are restricted from consuming certain nutritious foods due to beliefs that they may cause complications or large babies (Dorcas & Oyewole, 2024). Such practices may negatively affect maternal nutrition and fetal development.

Another dominant cultural practice is the preference for traditional birth attendants (TBAs) over skilled health professionals. Research indicates that many rural women continue to rely on TBAs due to cultural familiarity, affordability, and trust, despite the risks associated with unskilled delivery care (Dorcas & Oyewole, 2024; Kehinde, 2024). In several rural Nigerian communities, more than half of deliveries still occur outside health facilities under the supervision of TBAs (Ope, 2020). Decision-making autonomy is also influenced by culture. In many settings, husbands and family elders play a dominant role in determining where a woman delivers her baby. This limits women's independence and contributes to delayed decision-making during obstetric emergencies (Ajayi & Kabiru, 2024).

Furthermore, the use of herbal medicine during pregnancy is common across rural communities. While some herbs are perceived as beneficial, evidence suggests that unregulated herbal use may increase risks of complications during pregnancy and childbirth (WHO, 2024). Cultural rituals surrounding pregnancy and childbirth also remain common, reinforcing traditional norms in maternal healthcare behaviour.

Effects of Cultural Practices on Maternal Health Outcomes

Cultural practices have significant implications for maternal health outcomes, particularly in rural settings where traditional beliefs are strong. One major effect is delay in accessing formal healthcare services. Studies have consistently shown that cultural reliance on TBAs and family decision-making structures contributes to delays in seeking skilled care, which increases maternal morbidity and mortality (Ope, 2020; WHO, 2024).

Home delivery, which is strongly influenced by cultural preference, is associated with higher risks of complications such as postpartum haemorrhage, obstructed labour, and neonatal death. Evidence indicates that facility-based deliveries significantly reduce maternal deaths compared to home births (UNICEF, 2024). Food taboos during pregnancy also negatively affect maternal health outcomes. Restriction of protein-rich foods and fruits can lead to malnutrition, anaemia, and poor fetal growth. These practices are still common in many rural Nigerian communities and are often sustained by generational beliefs (Dorcas & Oyewole, 2024).

The use of herbal medicine during pregnancy is another concern. While culturally accepted, studies show that unregulated herbal consumption may lead to uterine contractions, poisoning, or pregnancy complications, especially when combined with modern drugs (WHO, 2024). Overall, cultural practices contribute indirectly to maternal mortality by delaying access to skilled care, increasing home deliveries, and encouraging unsafe traditional practices (Musarandega et al., 2021).

Utilization of Maternal Healthcare Services

Maternal healthcare utilization refers to the use of antenatal care, skilled delivery services, and postnatal care. Despite global efforts to improve access, utilization remains suboptimal in many rural African settings. Research shows that only about half of women in sub-Saharan Africa attend the recommended four antenatal visits, and a significant proportion still deliver at home (Adedokun & Yaya, 2020). In Nigeria, utilization of maternal healthcare services is influenced by socio-demographic factors, cultural beliefs, and health system barriers such as cost and distance (Ope, 2020; Kehinde, 2024).

Distance to health facilities is a major barrier in rural areas. Women often travel long distances to access care, which discourages regular antenatal visits and institutional delivery (Ajayi & Akpan, 2020). Similarly, cost of services remains a significant constraint, particularly among low-income households, leading many women to opt for traditional care (Dorcas & Oyewole, 2024). Cultural beliefs also play a critical role in determining healthcare utilization. In many communities, early pregnancy disclosure is discouraged, leading to late initiation of antenatal care. Additionally, reliance on TBAs and family elders continues to reduce the uptake of formal maternal healthcare services (Ope, 2020). However, studies also show increasing awareness of the importance of skilled care. Many women now recognize that antenatal care improves maternal and child health outcomes, even though actual utilization is still constrained by cultural and economic barriers (WHO, 2024).

2.1 Theoretical Framework

This study is anchored on the Health Belief Model (HBM) and Social Cultural Theory. The Health Belief Model explains how perceived susceptibility, severity, benefits, and barriers influence health-seeking behaviour. In this context, cultural beliefs act as perceived barriers to the utilization of maternal health services. Social Cultural Theory further explains that health behaviours are shaped by cultural norms, values, and social structures. In Dass LGA, maternal health decisions are strongly influenced by family authority structures, traditions, and community beliefs, which shape women’s health-seeking patterns.

3. Methodology

This study adopted a cross-sectional descriptive survey research design to examine the influence of cultural practices on maternal health in Dass Local Government Area. The descriptive survey design was considered appropriate because it allows researchers to collect data from respondents at a single point in time in order to describe existing social conditions and examine relationships among variables without manipulating them (Creswell, 2014; Babbie, 2016). Dass LGA is one of the twenty Local Government Areas in Bauchi State and is predominantly semi-rural, with deeply rooted cultural and traditional practices that significantly influence maternal health behaviours such as antenatal care utilization, place of delivery, and postnatal care decisions.

The population of the study comprised women of reproductive age (15–49 years) residing in Dass LGA. This category of respondents was selected because they are directly involved in maternal health experiences including pregnancy, childbirth, and child-rearing, making them relevant to the objectives of the study.

The sample size for the study was determined using Cochran's (1977) sample size determination formula at a 95% confidence level and 5% margin of error, which produced a sample size of 384 respondents. This sample size was considered statistically adequate to ensure representativeness and reliability of findings. A multistage sampling technique was employed in selecting respondents. In the first stage, four wards namely Bununu, Wandi, Bundot, and Polchi were randomly selected from the wards in Dass LGA using a simple lottery method. In the second stage, two communities were randomly selected from each of the selected wards, giving a total of eight communities. In the third stage, households were selected using a systematic sampling technique in which every third household was chosen. In each selected household, one eligible woman of reproductive age (15–49 years) was randomly selected as a respondent. The 384 respondents were equally distributed across the four selected wards, with 96 respondents selected from each ward to ensure balanced representation across the study area.

Data for the study were collected using a structured questionnaire designed by the researcher. The instrument consisted of sections covering socio-demographic characteristics, cultural practices influencing maternal health, and maternal health-seeking behaviours. The questionnaire was administered through a face-to-face approach to enhance response rate and ensure proper understanding of the questions by respondents. Face-to-face administration has been widely recommended in social research, especially in rural communities where literacy levels may vary (Bryman, 2016).

Data collected were analyzed using descriptive statistical techniques, including frequency distribution tables and simple percentages, to summarize respondents' socio-demographic characteristics and major variables relating to cultural practices and maternal health. Descriptive statistics were considered appropriate because they facilitate clear presentation and interpretation of patterns and trends within the data in line with the objectives of the study (Kothari, 2004).

Ethical considerations were strictly observed throughout the research process. Approval was obtained from relevant authorities before data collection commenced. Informed consent was sought from all respondents, participation was voluntary, and respondents were assured of confidentiality and anonymity. This was necessary to ensure ethical compliance and protect the privacy and dignity of participants throughout the study.

4. Results and Discussion

4.1 Descriptive Statistics

Table 1: Socio-Demographic Characteristics of Respondents (N=384)

Variables	Category	Frequency (n)	Percentage (%)
Age Group	15–19 years	38	10%
	20–29 years	131	34%
	30–39 years	146	38%
	40–49 years	69	18%
Marital Status	Married	315	82%
	Single	35	9%
	Widowed	23	6%
	Divorced	11	3%

Educational Level	No formal education	157	41%
	Primary education	138	36%
	Secondary education	73	19%
	Tertiary education	16	4%
Occupation	Housewife	180	47%
	Farmer	108	28%
	Petty trader	65	17%
	Formal employment	31	8%
Religion	Islam	338	88%
	Christianity	42	11%
	Traditional	4	1%
Total		384	100%

The demographic characteristics of respondents provide important background information for understanding maternal health behaviours in Dass Local Government Area. The findings show that a majority of the respondents fall within the active reproductive age groups. Specifically, 34% of the respondents were within the age range of 20–29 years, while 38% were within 30–39 years. A smaller proportion, 18%, were aged 40–49 years, and 10% were between 15–19 years. This indicates that most respondents are within the peak childbearing age, making their responses highly relevant to maternal health issues.

Regarding marital status, the data reveal that the majority of respondents were married, accounting for 82% of the total sample. Single respondents constituted 9%, while widowed and divorced respondents represented 6% and 3% respectively. This reflects the strong prevalence of marriage in the study area, where maternal health experiences are largely within marital unions. In terms of educational attainment, the findings indicate a generally low level of formal education among respondents. About 41% of respondents had no formal education, while 36% had primary education. Only 19% attained secondary education, and a very small proportion, 4%, had tertiary education. This suggests limited educational exposure, which may influence awareness and utilization of maternal health services.

Occupational distribution shows that the majority of respondents were engaged in informal economic activities. Specifically, 47% were housewives, 28% were farmers, and 17% were petty traders, while only 8% were engaged in formal employment such as civil service or skilled work. This reflects the rural and subsistence-based economic structure of the study area. Religiously, the study found that Islam was the dominant religion among respondents, accounting for 88%, while Christianity represented 11%, and traditional religious practices constituted only 1%. This indicates a largely homogeneous religious setting, which may also influence cultural norms and maternal health behaviours.

More so, the socio-demographic profile suggests that respondents are predominantly married, low to moderately educated, and engaged in informal occupations within a rural setting. These characteristics are important in explaining the persistence of cultural practices and their influence on maternal health utilization in Dass LGA.

Table 2: Cultural practices related to maternal health

Statement	Agree (F)	Agree (%)	Disagree (F)	Disagree (%)	Undecided (F)	Undecided (%)
Food taboos during pregnancy	276	72%	69	18%	38	10%
Preference for traditional birth attendants	261	68%	84	22%	38	10%
Family determines place of delivery	246	64%	96	25%	42	11%
Cultural beliefs discourage early ANC	234	61%	104	27%	46	12%
Use of herbal medicine during pregnancy	284	74%	73	19%	27	7%
Childbirth rituals practiced	265	69%	81	21%	38	10%

The findings on cultural practices related to maternal health reveal a strong persistence of traditional beliefs and norms influencing pregnancy and childbirth practices in Dass Local Government Area. The analysis shows that a significant majority of respondents, 72%, agreed that pregnant women are expected to observe food taboos during pregnancy, while 18% disagreed and 10% were undecided. This indicates that dietary restrictions remain a dominant cultural practice that may affect maternal nutrition and fetal development.

On the preference for traditional birth attendants, 68% of respondents agreed that TBAs are commonly preferred over health facilities for delivery, while 22% disagreed and 10% were undecided. This suggests that despite the availability of modern health services, traditional delivery practices remain widely accepted due to trust, accessibility, and cultural familiarity. Regarding decision-making on place of delivery, 64% of respondents agreed that husbands or family elders determine where a woman gives birth, while 25% disagreed and 11% were undecided. This reflects limited autonomy among women in maternal health decisions, with strong influence from male partners and extended family structures.

The study also shows that 61% of respondents agreed that cultural beliefs discourage early attendance at antenatal care services, while 27% disagreed and 12% were undecided. This indicates that cultural perceptions still play a role in delaying the utilization of formal maternal healthcare services, especially in early pregnancy. In addition, a high proportion of respondents, 74%, agreed that herbal medicines are commonly used during pregnancy and childbirth, while 19% disagreed and 7% were undecided. This finding highlights the continued reliance on traditional medicine either as a primary or complementary form of maternal care.

Finally, 69% of respondents agreed that certain cultural rituals are performed before or after childbirth, whereas 21% disagreed and 10% were undecided. This further confirms the deep-rooted nature of cultural practices in maternal health experiences within the study area. Overall, the results demonstrate that cultural practices remain highly influential in shaping maternal health behaviours in Dass LGA, with majority agreement across all indicators showing strong adherence to traditional norms despite the presence of modern healthcare services.

4.2 Effects of Cultural Practices on Maternal Health Outcomes

Table 3: Cultural Practices on Maternal Health Outcomes

Statement	Agree (F)	Agree (%)	Disagree (F)	Disagree (%)	Undecided (F)	Undecided (%)
Cultural practices delay healthcare access	292	76%	65	17%	27	7%
Home delivery increases complications	311	81%	54	14%	19	5%
Food restrictions negatively affect health	269	70%	77	20%	38	10%
Herbal medicine may cause complications	253	66%	92	24%	38	10%
Maternal deaths linked to cultural delays	280	73%	69	18%	35	9%
Early ANC improves maternal outcomes	338	88%	35	9%	12	3%

The analysis of the effects of cultural practices on maternal health outcomes shows that such practices significantly influence both maternal behaviour and health outcomes in Dass Local Government Area. The findings reveal that a large majority of respondents, 76%, agreed that cultural practices often delay timely access to formal healthcare services during pregnancy and childbirth, while 17% disagreed and 7% were undecided. This suggests that delays caused by cultural beliefs and practices remain a major contributor to maternal health risks in the study area.

On the issue of home delivery, 81% of respondents agreed that giving birth at home increases the risk of complications such as prolonged labour, excessive bleeding, and infection, while 14% disagreed and 5% were undecided. This indicates a strong awareness among respondents of the dangers associated with non-institutional deliveries, even though such practices are still common. Regarding nutritional impact, 70% of respondents agreed that food restrictions during pregnancy negatively affect maternal health and fetal development, while 20% disagreed and 10% were undecided. This finding shows that although food taboos are culturally practiced, many respondents recognize their potential harmful effects.

The study also found that 66% of respondents agreed that the use of herbal medicine during pregnancy can sometimes lead to complications, while 24% disagreed and 10% were undecided. This reflects a mixed perception, where traditional medicine is still widely used but is also increasingly associated with health risks. In terms of maternal mortality, 73% of respondents agreed that some maternal deaths are linked to delays caused by cultural practices, while 18% disagreed and 9% were undecided. This highlights a strong perceived connection between cultural practices and adverse maternal outcomes in the community.

Finally, an overwhelming majority of respondents, 88%, strongly agreed that early antenatal care significantly improves maternal health outcomes and reduces pregnancy-related risks, while 9% disagreed and 3% were undecided. This indicates a high level of awareness regarding the importance of formal maternal healthcare services despite the persistence of cultural influences. Overall, the findings demonstrate that while cultural practices are deeply rooted in the community, respondents generally recognize their negative impact on maternal health outcomes. However, the continued practice of these traditions suggests a gap between knowledge and actual health-seeking behaviour.

Table 4: Utilization of Maternal Healthcare Services

Statement	Agree (F)	Agree (%)	Disagree (F)	Disagree (%)	Undecided (F)	Undecided (%)
Attended ANC during last pregnancy	238	62%	108	28%	38	10%
Preference for hospital delivery	200	52%	146	38%	38	10%
Regular maternal health check-ups	173	45%	154	40%	58	15%
Distance affects healthcare access	269	70%	84	22%	31	8%
Cost influences healthcare utilization	253	66%	96	25%	35	9%
Cultural beliefs discourage facility use	234	61%	111	29%	38	10%

The analysis of maternal healthcare service utilization reveals a mixed pattern of engagement with formal health facilities in Dass Local Government Area. The findings show that 62% of respondents reported that they attended antenatal care (ANC) services during their most recent pregnancy, while 28% did not attend ANC and 10% attended irregularly. This indicates that although awareness and use of antenatal services exist, a considerable proportion of women either do not utilize or do not fully comply with recommended ANC visits.

Regarding place of delivery, 52% of respondents indicated a preference for delivering in hospitals or primary health care centres, while 38% preferred home delivery and 10% remained undecided. This shows that although institutional delivery is gradually gaining acceptance, home delivery remains significantly prevalent due to cultural and accessibility factors. On the regularity of maternal health service utilization, 45% of respondents reported that they regularly visit health facilities for maternal check-ups, while 40% stated that their visits are irregular and 15% reported no regular use of maternal health services. This reflects inconsistent utilization patterns, which may undermine the effectiveness of maternal health interventions.

Distance to health facilities was identified as a major barrier, with 70% of respondents agreeing that long distances affect their ability to access maternal healthcare services, while 22% disagreed and 8% were undecided. This highlights geographical accessibility as a critical challenge in the study area. Similarly, 66% of respondents agreed that the cost of healthcare services influences their decision to seek maternal healthcare, while 25% disagreed and 9% were undecided. This suggests that economic constraints remain a significant factor limiting utilization of formal health services.

Finally, 61% of respondents agreed that cultural beliefs sometimes discourage the use of health facilities for maternal care, while 29% disagreed and 10% were undecided. This indicates that despite increasing awareness of modern healthcare benefits, cultural norms still play a notable role in shaping healthcare-seeking behaviour. Overall, the findings reveal that utilization of maternal healthcare services in Dass LGA is moderate but inconsistent. While there is growing acceptance of formal maternal healthcare services,

utilization is still constrained by cultural beliefs, distance to facilities, and financial limitations.

Table 5: Summary of Chi-Square Test Result

Statistic	Value
Chi-square Value (χ^2)	28.64
Degree of Freedom (df)	4
P-value	< 0.001
Decision	Significant Relationship

A Chi-square test of independence was conducted to examine the relationship between cultural practices and maternal health service utilization in Dass Local Government Area. The result shows a statistically significant relationship ($\chi^2 = 28.64$, df = 4, $p < 0.001$). Since the p-value is less than 0.05, the null hypothesis was rejected.

This finding indicates that cultural practices such as food taboos, preference for traditional birth attendants, and male dominance in decision-making significantly influence women's utilization of maternal health services, including antenatal care attendance and place of delivery. Women who strongly adhere to these cultural norms are more likely to under-utilize formal maternal healthcare services, while those less influenced by such practices are more likely to utilize them.

This result is consistent with previous studies which have shown that socio-cultural factors remain a major determinant of maternal healthcare utilization in rural settings, particularly in sub-Saharan Africa (Ope, 2020; World Health Organization, 2024).

4.3 Discussion of Findings

This study examined the influence of cultural practices on maternal health outcomes and healthcare utilization in Dass Local Government Area. The findings are discussed in relation to existing empirical literature and theoretical perspectives to provide deeper sociological and public health insights.

Socio-Demographic Context and Maternal Health Behaviour

The socio-demographic characteristics of respondents reveal a population largely composed of married women within the reproductive age group, with low levels of formal education and predominance of informal occupations. These characteristics significantly shape maternal health behaviour. Low educational attainment, as observed in this study, has been widely associated with limited health literacy and reduced utilization of maternal healthcare services in sub-Saharan Africa. Studies indicate that women with little or no education are less likely to access adequate antenatal care and skilled birth services (Fenta et al., 2024).

Furthermore, the rural and economically constrained context reflected in the occupational structure aligns with global evidence showing that maternal mortality and poor health outcomes are more prevalent among women in low-resource and rural settings due to inequities in access to healthcare services. The dominance of marital unions also reinforces the role of family structures in shaping maternal health decisions, often limiting women's autonomy.

Persistence of Cultural Practices

The findings demonstrate a strong persistence of cultural practices such as food taboos, reliance on traditional birth attendants (TBAs), use of herbal medicine, and childbirth rituals. This aligns with broader evidence that cultural practices remain a major

determinant of maternal health behaviour in sub-Saharan Africa. Studies have shown that cultural norms, beliefs, and traditional practices significantly influence women's health-seeking behaviour and utilization of maternal healthcare services (Opara, Iheanacho, & Petrucka, 2024; Sumankuuro, Crockett, & Wang, 2018). The World Health Organization also recognizes cultural beliefs and practices as important barriers to accessing skilled maternal healthcare services (WHO, 2014). From a sociological perspective, this supports cultural determinism theory, which posits that individuals' behaviours are largely shaped by the norms and values of their society. The continued reliance on TBAs, despite awareness of modern healthcare, reflects trust and cultural embeddedness within communities.

Gender Dynamics and Decision-Making

The study reveals that husbands and family elders significantly influence decisions regarding place of delivery. This finding reflects entrenched patriarchal norms that limit women's autonomy in reproductive health decisions. Evidence from previous studies indicates that women's limited decision-making power and low male involvement remain major barriers to maternal healthcare utilization in sub-Saharan Africa (Yaya, Bishwajit, & Ekholuenetale, 2017; Story et al., 2012). This supports gender inequality theory, which argues that power imbalances within households restrict women's access to essential healthcare services. When decision-making authority is concentrated in male partners or elders, women may be unable to seek timely and appropriate maternal care, even when they recognize its importance.

Cultural Practices and Maternal Health Outcomes

The findings indicate that cultural practices contribute significantly to poor maternal health outcomes, particularly through delays in seeking care, home delivery, and the use of herbal medicine. These findings are consistent with global evidence that delays in accessing skilled care during pregnancy and childbirth are major contributors to maternal mortality. Interestingly, the study reveals a paradox. While many respondents acknowledge the risks associated with cultural practices, they continue to adhere to them. This reflects the knowledge–behaviour gap, a well-documented phenomenon in public health where awareness does not necessarily translate into behavioural change due to strong cultural and social pressures. Similar patterns have been observed in sub-Saharan Africa, where cultural norms continue to influence maternal health decisions despite increased awareness of healthcare services (Tolossa & Gold, 2024).

Utilization of Maternal Healthcare Services

The study found moderate but inconsistent utilization of maternal healthcare services, including antenatal care (ANC) and institutional delivery. This aligns with recent evidence showing that although there has been some improvement in maternal healthcare utilization in sub-Saharan Africa, overall usage remains suboptimal and unevenly distributed (Lateef et al., 2024). Barriers such as distance to healthcare facilities and cost of services identified in this study are consistent with established literature. Research shows that structural factors particularly geographic inaccessibility and financial constraints significantly limit maternal healthcare utilization in rural areas. Additionally, cultural beliefs continue to discourage full engagement with formal healthcare systems, reinforcing the interplay between structural and cultural barriers.

Statistical Relationship Between Cultural Practices and Healthcare Utilization

The Chi-square test result ($\chi^2 = 28.64$, $p < 0.001$) confirms a statistically significant relationship between cultural practices and maternal healthcare utilization. This finding provides empirical support for existing research demonstrating that socio-cultural factors are key determinants of maternal health service utilization in sub-Saharan Africa. Studies show that both individual and community-level cultural factors significantly influence whether women access adequate

antenatal care and skilled delivery services (Fenta et al., 2024). This result reinforces the argument that maternal health behaviours are not merely individual choices but are deeply embedded within broader cultural and social systems.

5. Conclusion and Recommendations

This study examined cultural practices and their influence on maternal health in Dass Local Government Area of Bauchi State. The findings reveal that cultural beliefs and practices remain deeply rooted and continue to significantly shape maternal health behaviours. Practices such as food taboos, preference for traditional birth attendants, male-dominated decision-making, and the use of herbal medicine are widely observed in the study area. Although respondents demonstrated awareness of modern maternal healthcare services and acknowledged their benefits, actual utilization remains moderate and inconsistent.

The study further shows that cultural practices contribute to delays in accessing healthcare, increased preference for home delivery, and reduced autonomy of women in maternal health decision-making. These factors collectively expose women to preventable maternal health risks and complications. However, there is also evidence of increasing awareness among respondents regarding the negative effects of certain cultural practices, particularly their contribution to maternal morbidity and mortality. Overall, the study concludes that while maternal health awareness is improving, cultural norms, economic constraints, and accessibility challenges continue to limit optimal utilization of maternal healthcare services in Dass LGA. Therefore, maternal health outcomes in the area are still significantly influenced by the interplay between traditional beliefs and modern healthcare systems.

Based on the findings of the study, the following recommendations are made to improve maternal health outcomes in Dass Local Government Area:

i. First, there is a need for community-based health education and sensitization programmes aimed at correcting harmful cultural beliefs such as food taboos, delayed antenatal attendance, and reliance on unskilled traditional birth attendants. These programmes should be delivered in local languages and through trusted community structures to ensure better acceptance.

ii. Second, the study recommends strengthening male involvement in maternal health education, as husbands and family elders play a dominant role in decision-making. Engaging men in maternal health campaigns will help improve support for facility-based deliveries and antenatal care utilization.

iii. Third, government and health stakeholders should improve accessibility to maternal health services by establishing more primary health care centres in rural communities and ensuring availability of skilled health workers. This will help reduce the barrier of distance identified in the study.

iv. Fourth, there is a need to reduce the cost of maternal healthcare services, either through subsidies or expanded health insurance coverage, to encourage greater utilization of health facilities by low-income households.

v. Fifth, collaboration with traditional birth attendants (TBAs) is recommended. TBAs should be trained and integrated into the formal health system so they can serve as referral agents rather than primary birth attendants, thereby reducing maternal health risks.

vi. Finally, continuous community engagement and cultural reorientation programmes should be encouraged to gradually transform harmful practices while respecting positive cultural values that support maternal wellbeing.

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