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Iwo-Amah RS
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Mkpe Abbey
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Amadi SC
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Kua P
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Inimgba N
PAMO University of Medical Sciences, Port Harcourt, Nigeria

Altraide BO
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Nonye-Enyindah E
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Okagua K
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Ocheche US
PAMO University of Medical Sciences, Port Harcourt, Nigeria

Awoyesuku P
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Kwosah NJ
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

John DH
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Mba AG
PAMO University of Medical Sciences, Port Harcourt, Nigeria

Awopola J
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Ohakah C
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Ngeri B
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Wekere FCC
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Corresponding Author:
Iwo-Amah RS
Department of Obstetrics and Gynaecology, Rivers State University Teaching Hospital, Port Harcourt, Nigeria

Socio cultural factors and religious practices in Nigeria, as it affects women of reproductive age: A study in Niger delta, Nigeria

Iwo-Amah RS, Mkpe Abbey, Amadi SC, Kua P, Inimgba N, Altraide BO, Nonye-Enyindah E, Okagua K, Ocheche US, Awoyesuku P, Kwosah NJ, John DH, Mba AG, Awopola J, Ohakah C, Ngeri B and Wekere FCC

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Abstract
Background: Culture, tradition and religion of any community, has a major role to play in the reproductive outcome of the women from that area.
Recent research publications acknowledge the influence of religion and culture on Sexual and reproductive behaviour and health-care utilization.
The Reproductive age woman (15-49 years) in Nigeria is faced with a lot of health challenges that are closely linked to the socio-cultural, traditional and religious beliefs of the people in her immediate Community.
Culture and tradition have their positive aspects, but we want to highlight the harmful effects that lead to high indices of maternal mortality in Nigeria and Africa in general.
The aim is to continue to draw attention of the United Nations (UN), World Health Organization (WHO), Government and donor Organizations to the plight of the Nigerian
woman, especially the rural dwellers.
Method: We used a qualitative method and performed three types of data collection with different target groups.
The result was that the United Nations Convention on Elimination of all forms of Discrimination against women (art 5a), by General Assembly resolution 34/180 of 18th December 1979 is yet to gain full impact in Nigeria.

Keywords: Socio cultural, religious, reproductive age

Introduction
Sociocultural and religious beliefs of a people or Community has a strong influence on the Reproductive outcome of their women, because it determines their health seeking behaviour. Culture can be defined as a collection of easily identified beliefs and practices shared by a group of people, which guides their decision, thinking and actions in a patterned way.
Culture and tradition also include religion, cuisine, Social habits, beliefs, music and the arts [2].
African culture, especially West Africa has a great impact on the health of women from these areas. Inadequate exposure to modern Technology, poor awareness of new scientific discoveries and research, poor availability of new drugs and facilities, combine to make health delivery poor in these third world countries.
Culture has good and bad aspects. The belief that a woman is not married to her husband lone, but to his entire family has the advantage of having members of the extended family to take care of the new born during the puerperium, so that the mother can have adequate rest. Prolonged period of breast feeding is also an advantage.
However the disadvantages of sociocultural, traditions and religious practices seem to be enormous.
Recent research publications acknowledge the influence of Religion and culture on sexual and Reproductive behaviour and health care utilization. According to World Health Organization (WHO) Nigeria accounts for over 34 per cent of global maternal deaths [2]. The life time risk of dying during pregnancy, childbirth, post-partum, or after an abortion for a Nigerian woman is 1 in 22, compared to 1 in 4,900 in developed countries [2, 5, 6].

Socio cultural, traditional and religious factors have been identified as contributing to these high figures.
The reproductive age woman (15-49years) in Nigeria is faced with a lot of health challenges that are closely linked with Societal perception of her and the girl child. This is more pronounced in the rural areas where challenges such as child marriages, early marriages, forced Marriages, female Genital mutilation (FGM), poor access to good education, poverty, lack of financial empowerment, Male dominance, poor nutrition, nutritional taboos as a girl child, pregnant or lactating mother, male child preference and inability to decide for herself when, where and how to get health care. This increases the incidence of Type I Delay Causing Maternal mortality, maternal near-miss and maternal morbidity.
Patronage of Traditional Birth Attendants (TBA) and faith healing homes is also common.
Tradition also expects the pregnant woman to live with her mother-in-law or her mother when she is due. The over-riding influence of mother-in-law or sister -in-law could lead to negative pregnancy outcome.

Method

We used a qualitative method for this study, and performed three types of data collection with different target groups.

1. Questionnaires were distributed to 56 Gynaecologists in a Sector SOGON meeting. Fifty of these questionnaires were adequately filled, and retrieved by the first author
2. Four focus group discussions with health workers in Local Governments of Rivers state were conducted.
   The Local Governments were Obio-Akpor Local Government area, Ahoada Local Government area, Okrika Local Government and Emuoha Local Government area
3. Ten case studies among family members of deceased mothers were done.

Information requested in the questionnaire included Age, sex, gender, Place of practice and duration of Practice, Is there any relationship between reproductive outcome of our women with the Socio-cultural and religious background? What are their suggestions to improve reproductive outcome? All the focus group discussions were audio recorded and notes taken.
In order to obtain points of view of families where maternal death had occurred, ten case studies among family members of deceased mothers were also conducted. This occurred in the four Local Governments where health workers were also interviewed. The rural health workers identified a person who had remained close to the deceased mother throughout her pregnancy and delivery. Those included were those whose maternal death occurred within the last 2 years and occurred due to complication of Pregnancy, child birth or puerperium
Data analysis was performed manually using thematic analysis. All the initial codes related to the research questions were joined together and transformed into a theme. The study used both a deductive and inductive approach for data analysis. Analytic induction and constant comparison of the categories were applied the themes derived from the data analysis are presented below.
All the interviews and focus group discussions were audio recorded and notes were taken.

Results

Women are subjected to early marriages, forced marriages in which they are not physically, anatomically and psychologically well developed to cope.
They get pregnant at very early age with all the complications of teenage pregnancy,
They have anaemia in Pregnancy, poor nutrition and may end up with Cephalopelvic disproportion in Labour.
They seek health care at the Traditional Birth Attendant's place or the Faith Healing homes. They end up being referred to the hospital at a stage where it may be difficult to salvage their lives. Thus increasing the maternal mortality indices in Nigeria.
Those that survive may have Vesico Vaginal Fistula (VVF) or Recto vaginal fistula.
Some of the women are subjected to Female Genital Mutilation (FGM) before puberty, after puberty or during pregnancy. FGM is surgical removal of part or all of the most sensitive female external genitalia.
The complications of FGM, which include immediate, and remote complications, make labour and delivery difficult for the affected women.
Poverty, lack of financial empowerment and inability to decide where, when and how to access health care was also a major problem for women in Nigeria.
The Health workers informed us that the mother-in-law are the ones who decide the next course of action when a pregnant mother is brought to them. The husband, on whoever is paying the bills determines what should be done for the pregnant woman.
Majority of the women have poor education, because of Preference for the male child. They hardly have well-paying jobs. Poverty and deprivation is more among the rural women. Ignorance about family planning methods and Child spacing was a major issue. This led to large families with lean resources.
The food taboos during pregnancy and lactation further depleted their immune system and haemoglobin levels. Women were thus prone to infections including Sexually Transmitted Diseases (STD) and AIDS.
Traditions where father in law and brothers of husbands were allowed to have sexual inter-course with the woman further exposed her to infections. There was a case in which the woman was abandoned in the Health Centre, when the husband discovered that she had given birth to twin female babies. This is based on the idea of the inferiority of the female gender over the male.

Table 1: Socio demographic characteristics of health workers in four local government areas

Variables	n=38	percentages
Sex		
Male	10	26.3
Female	28	73.7
Total	38	100
Age (years)		
25-30	4	10.53
31-35	14	36.84
36-40	15	39.47
>40	5	13 16
Total	38	100
Marital status		
Married	31	81.6
Single	7	18.4
Total	38	100
Variables Parity	n=38	Percentage
0-1	5	13.20
2-3	11	28.94
4-5	18	47.36
>5	4	10.50
Total	38	100

A total of 38 health workers were interviewed. Most of them were females 28 (73.7%). Apart from their encounter with the rural woman, some of the health workers had personal experiences of the effect of culture and tradition on women, which they shared with us.

Most of the health workers 76.31% were between 31-40 yrs. Most of them were married (81.6%).

Highest number of the health workers had 4-5 children, 18(47.36%) Most of them had work experience of 5-10yrs (84.21%)

Table 2: Socio demographic characteristics of gynaecologists who responded

Variables	n=50	Percentage
Sex		
Male	32	64%
Female	18	36%
Total	50	100%
Age		
25-30	5	10%
31-35	10	20%
36-40	28	36%
>40	1	14%
Total	50	100%
Marital status		
PA-grief'	47	94%
Single	3	6%
Total	50	100%
Parity		
0-1	15	30
2-3	23	46
4-5	11	22
>5	1	2
Total	50	100%
Work Experience		
5-10 Years	41	AA%
>10yrs	7	14%
Total	50	

Majority of the Gynaecologists were males-32 (64%). Most of them were within 31-40 years (56%). Ninety-four percent (94%) were married. Parity of 2-3 children was highest (46%) and most of the gynaecologists had work experience of 5-10 yours (86%).

Discussion

Reducing Maternal mortality is among the key determinants of development strategies for countries all over the world.

A number of countries throughout the world have either taken or Supported actions to prevent traditional practices affecting the woman and children, in particular, Female genital mutilation (FGM)'. These countries include Bangladesh, Sudan, Sweden, United Kingdom United States of America and Norway1,2.

From the above study, appreciable changes have not occurred in Nigeria.

Many studies have documented the association between religious, social and cultural beliefs and the health risks faced by child bearing women [1, 2, 3, 4, 5].

Despite their harmful nature and violation of International human rights law, such practices persist because they are not questioned, and take on an aura of morality in the eyes of those practising it. Also these practices have been performed for male benefit and even Governments and the international community had not expressed Sympathy and understanding for women who, due to ignorance of their rights, endure pain, sufferings, and even death inflicted on themselves and their female children.

Access to education by itself is not enough to eliminate values held by society, such values are in most countries transmitted into educational curricula and textbooks.

Conclusion

Sociocultural, traditional and religious practices have their Positive and Negative influences on the people who practice them. In Nigeria, the negative influences or effects on women in Reproductive age should be reviewed and abolished if possible.

Education of the girl child should be compulsory. Education offer the woman an improved opportunity to be less dependent on men in later life. It increases her prospects of obtaining work outside the home. Education is directed to the development of the child's personality, talents, mental and physical abilities to their fullest potential.

Most women in developing countries are unaware of their basic human rights. Even when women acquire a degree of economic and political awareness, they often feel powerless to bring about the change necessary to eliminate gender inequality.

The United Nations (UN), World Health Organization (WHO) and many international legal instruments on human rights further reinforce individual rights, and also protect and prohibit discrimination against specific groups, in particular women and that It affirms the equality of human rights for women and men in Society and in the family, it calls for the elimination of Laws, stereotypes, practices and prejudices that impair women's well-being.

Maternal mortality, maternal near-miss and maternal morbidity indices will improve remarkably

In Nigeria and Africa if these laws are re-enforced, and harmful socio cultural, traditional and religious practices are abolished

Conflict of Interest

Not available

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