Exposure of Hausa Women to Mass Media Messages: Health and Risk Perception of Cultural Practices affecting Maternal Health in Rural Communities of Bauchi State, Nigeria

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Abstract

This study aims to determine the exposure of Hausa women in rural areas of Bauchi state to health messages from the Mass Media, with a view to ascertaining if these messages have a bearing on their perception of risk regarding prevalent cultural practices relating to maternal health. A review of the literature indicates that the mass media promote the communication of health messages, and have contributed to health promotion and disease prevention; thus, dissemination of health messages through public education campaigns via the mass media can seek to change the social climate, to encourage healthy behaviours, create awareness, change attitudes, as well as motivate individuals to adopt recommended behaviours, such as lowering risk perceptions. A Focus Group Discussion was used to gather data from women of child-bearing age in the study area. Findings showed that some cultural practices detrimental to maternal health are still prevalent and such practices are mostly not perceived as risky. Also, although women encounter health messages (mostly through
radio and posters) that are contextually relevant in addressing problems associated with maternal health, none of these are centred specifically on harmful cultural practices. Based on the aforementioned, it is recommended that relevant authorities concerned with the welfare of women prioritise the dissemination of mass media messages/campaigns that could contribute to the improvement of women’s health, to minimize the problems affecting maternal health. Also, cultural practices that persist in these areas should be researched with a view to ascertaining their strengths, to emphasize the assimilation of the positive aspects into the packaging of mass media messages/campaigns.

Figure 1: Map of Nigeria illustrating regions and constituent states. (Source NDHS 2018)

Figure 2: Trends in pregnancy-related maternal mortality ratio recorded by NDHS 2018. Deaths represent an aggregate of data for the seven years preceding the year of survey.
Introduction

Culture has a profound impact on maternal health. According to Helman (2001), cultural beliefs shape a range of factors that affect reproductive health, such as fertility patterns, contraceptive use, maternal health-seeking behaviour, and choice of birth attendant. Traditional knowledge, medicine and childbirth in the home are still important to some cultures, especially in rural environments where there are social, economic and political barriers to accessing medical treatment.

According to Issayas (1996:3), “while many of these traditional medical practices have helped people struggling against various types of illness and managed ordeals of pregnancy and child delivery, some practices have proved to be harmful and detrimental to the people’s health, particularly women and children”. Women’s overall health and nutritional status, pregnancy outcomes and other reproductive health problems are the major causes of maternal mortality, especially in Nigeria.

There are significant disparities in maternal mortality rates between the regions of Nigeria, with Northern Nigeria, constituted primarily of Hausa and Fulani ethnic groups and a predominantly Muslim population (Sinai et al, 2017), having higher maternal mortality rates than Southern Nigeria. The poor maternal health record in Northern Nigeria has qualified the region as one of the leading non-hospitable areas on earth for pregnant women (Pate & Dauda, 2013). These maternal mortality rates are even higher when the North-East region is considered separately, with an estimated maternal mortality rate of 1,549, more than five times the global average (Abimbola et al, 2012, cited in Cooke & Tahir, 2013), being recorded.

Bauchi state is a predominantly rural state located in the North-Eastern part of Nigeria. Despite the high level of media awareness and prevalence of campaigns, especially on issues relating to health (Berry, 2004), Bauchi state records high levels of maternal mortality (NDHS, 2018), with a similarly high total fertility rate of 7.2. The 2018 NDHS report indicated that 51.6% of women of childbearing age in Bauchi state got antenatal care from a skilled provider (3% from a doctor, 46.0% from a nurse/midwife and 2.6% from auxiliary nurses and midwives), while 15.0% got antenatal from other (community) health workers. Although traditional birth attendants and others gave care to 1.2% of the surveyed women, as many as 33.1% had no antenatal care. Whereas in 2008, only about 12% delivered in a health facility, by 2018, this figure had risen to 21.8% (NDHS, 2008; NDHS, 2018). In spite of the seeming improvement over the years, the maternal health situation in Bauchi and other parts of northern Nigeria is more critical than it is in southern regions.
Table 1. Breakdown of antenatal care providers for North-Eastern states.

| State   | Doctor (%) | Nurse/midwife (%) | Auxiliary nurse/midwife (%) | Other health worker (%) | Traditional birth attendant (%) | Other (%) | No ANC (%) |
|---------|------------|-------------------|-----------------------------|------------------------|-------------------------------|-----------|------------|
| Adamawa | 0.7        | 80.8              | 0.6                         | 1.9                    | 0.4                           | 0.2       | 15.4       |
| Bauchi  | 3.0        | 46.0              | 2.6                         | 15.0                   | 0.2                           | 0.1       | 33.1       |
| Borno   | 3.7        | 44.2              | 2.9                         | 11.5                   | 0.0                           | 0.1       | 37.6       |
| Gombe   | 1.9        | 16.9              | 27.6                        | 26.2                   | 1.6                           | 0.4       | 25.4       |
| Taraba  | 7.2        | 49.1              | 1.1                         | 21.6                   | 0.0                           | 0.6       | 20.4       |
| Yobe    | 8.9        | 50.8              | 6.6                         | 1.0                    | 0.0                           | 2.5       | 30.2       |

Figure 3: Breakdown of antenatal care providers for Bauchi state. (Derived from NDHS 2018)
Figure 4: Comparison of deliveries without antenatal care by region. (Derived from NDHS 2018)

Table 2. Breakdown of place of delivery by region. (Derived from NDHS 2018)

| Region       | Home (%) | Health facility (%) | Other (%) |
|--------------|----------|---------------------|-----------|
| North Central| 50.1     | 49.2                | 0.7       |
| North East   | 74.5     | 25.4                | 0.1       |
| North West   | 84.4     | 15.6                | 0.0       |
| South East   | 17.2     | 81.8                | 1.0       |
| South South  | 43.8     | 50.2                | 6.0       |
| South West   | 16.8     | 76.3                | 6.9       |

Table 3. Breakdown of place of delivery for North-Eastern states. (Derived from NDHS 2018)

| State    | Home (%) | Health facility (%) | Other (%) |
|----------|----------|---------------------|-----------|
| Yobe     | 83.8     | 16.2                | 0         |
| Bauchi   | 78.1     | 21.8                | 0.1       |
| Borno    | 73.8     | 26.2                | 0         |
| Gombe    | 72.2     | 27.7                | 0.1       |
| Taraba   | 69.8     | 30                  | 0.2       |
| Adamawa  | 60.7     | 38.9                | 0.4       |
One reason for the poor maternal health in northern Nigeria is the strong attachment to cultural beliefs and practices. Doctor, Bairagi, Findley, Helleringer, & Dahiru, (2011:11) posit that “strong cultural beliefs and practices on childbirth and fertility related behaviours partly contribute to the maternal morbidity and mortality picture.
compared to southern Nigeria”. Bauchi state comprises over 55 ethnic groups, the main ones being Hausa, Fulani, Gerawa, Sayawa, Jarawa, Bolawa, Kare-Kare, Warjawa, Zulawa and Badawa. Each of these ethnic groups has their languages, settlements, customs, festivals, beliefs and other features distinct from others (Statistical Yearbook, 2006). With respect to the health care of the people in Hausaland, certain beliefs and traditions have been culturally developed, nurtured, and sustained. Hence, Hausa women commonly hold to a set of cultural practices regarding maternal health. While some of these practices have served the people positively, others have proven harmful to maternal health.

Traditional practices and beliefs held by local women in their pregnancy and during childbirth usually informs their understanding of pregnancy. The reasons for retaining such practices are varied, and include belief in the efficacy of traditional healing practices, difficulties in accessing modern health care services, or wrong perceptions about the harmful effects of the practices being upheld. Consequently, the risks associated with specific activities can be misjudged, due to a lack of information. It is on this premise that this study examines whether women of Hausa extraction in the rural areas of Bauchi state are exposed to messages from the mass media regarding certain harmful cultural practices that relate to maternal health, and if the provision of health-based messages through the mass media plays a role in influencing the risk perceptions they hold based on the maintenance of these cultural practices.

Figure 7: Illustration of women’s educational attainment by state. The percentage refers to the number of women who have completed at least a secondary school education.

(Derived from NDHS 2018)
Table 4. Breakdown of women’s educational attainment for North-Eastern states of Nigeria. (Derived from NDHS 2018)

| State   | No education (%) | Some primary (%) | Completed primary (%) | Some secondary (%) | Completed secondary (%) | More than secondary (%) |
|---------|------------------|------------------|-----------------------|--------------------|-------------------------|-------------------------|
| Adamawa | 47.0             | 3.4              | 9.1                   | 13.7               | 20.7                    | 6.2                     |
| Bauchi  | 63.4             | 8.5              | 9.7                   | 9.7                | 5.9                     | 2.7                     |
| Borno   | 58.5             | 2.2              | 5.9                   | 9.5                | 11.7                    | 12.3                    |
| Gombe   | 64.8             | 4.1              | 5.5                   | 11.3               | 10.0                    | 4.4                     |
| Taraba  | 36.7             | 12.0             | 9.7                   | 19.8               | 13.8                    | 8.1                     |
| Yobe    | 75.5             | 3.3              | 4.9                   | 5.9                | 7.4                     | 3.0                     |

Research Questions

The following are the research questions of the study:

1. What are the prevalent cultural practices relating to maternal health among Hausa women in rural areas of Bauchi State?

2. What is the extent of exposure to mass media health messages, specifically maternal health messages among women in the study area?

3. What is the risk perception level of the cultural practices among women in the study area?

Mass Media and Health Promotion

The mass media are dominant features of our day to day life and available both in domestic and public environments. They tend to engage people, convey information, and produce reactions in their audiences that justify their continued production. While the main message is sometimes clear, it is also likely that some other meaning is produced in the minds of the audience unconsciously (Gupta & Sinha, 2010:19).

The success of any mass media message depends on the message reaching its target audience and being interpreted and applied appropriately. In some cases, the aim is to change behaviour, for instance, by encouraging people to stop smoking, practice
safe sex, or eat more healthily. Mass communication via the mass media therefore raises a number of challenges, such as identifying and reaching the right audience, and ensuring that the message is appropriate for that audience and is likely to be acted on (Berry, 2007:25). Mass media are tools for the transfer of information, concepts, and ideas to both general and specific audiences. Through the mass media and other nodes in their network, individuals are exposed to multiple ideas (Barber & Axinn, 2004). For instance, mass media can convey information about health and make people aware of preventive measures to stop the spread of various diseases. The mass media also have the power to direct our attention towards certain issues, as advanced and documented by the agenda-setting theory. Not only do people acquire factual information about public affairs from the mass media, the audience also learns how much importance to attach to a topic on the basis of the emphasis placed on it in the news or any other programme.

Many people rely on the mass media for health-related information. Policy makers also obtain considerable amount of information from the media. Bryant & Thompson (2002) have suggested that media coverage of health matters takes on considerable significance that has the potential to shape the impression of average citizens and powerful policy makers alike. Hence, the mass media play an important role in disseminating health information to the public, especially in much of modern society. According to Berry (2007:103), the mass media enables the conveyance of information on a whole range of health topics directly into the homes of a large proportion of the population. As such, mass media campaigns have long been a tool for promoting public health.

According to Schiavo (2007), access or exposure to the mass media has brought images of models and lifestyles from different cultures into many homes across the world that over time, can be assimilated or emulated by a given culture. However, it would be naïve to expect that people will not incorporate their traditional beliefs and social values in redefining health as a result of new information and models, because, “for any given culture, new ideas of health and illness tend to be the result of a carefully balanced combination of pre-existing and new concepts” (p. 77).

**Traditional Practices in Maternal Health and Risk Perception**

Traditional approaches to health are based on unique cultural perceptions of the illness and of the healing process. Despite the harmful nature of some of these practices, they persist either because they have not been questioned, they have taken on an aura of morality, or because of the notion of being in control of the accompanying risk associated with such practices.
There are cultural factors that contribute to women dying in pregnancy, labour and puerperium, which most of the time are neglected. Some of these factors include harmful traditional practices such as food taboos and restrictions associated with the pre- and post-partum periods of a woman’s life, as well as Female Genital Mutilation and similar practices (Marchie, 2012). This means that in addition to medical causes of maternal mortality, there are socio-cultural factors that contribute to women dying during pregnancy, labour and post-partum.

A study conducted by Shamaki & Buang (2014), which focused on maternal health of women in Sokoto State (north west Nigeria), reviewed data and information from official government documents and relevant academic research and journal articles conducted by critical global actors in the sector, such as the United Nations Population Fund (UNFPA), the Targeted States High Impact Project (TSHIP) of USAID, and Pathfinder International. These showed that tradition-inspired practices and norms such as unattended labour and delivery, low level of education, hot bath (wankan jogo) during new birth, use of herbs, and forced/early marriage, played significant roles in maternal health, and were believed to account for the high maternal mortality rates in the state. The study also states that even though such practices are predominant among women with low educational attainment, their general influence remains strong even in the face of extensive modernization. Consequently, these issues need to be addressed more squarely if maternal mortality is to be reduced.

Table 5. Occupational patterns of women in the North-Eastern states of Nigeria. (Derived from NDHS 2018)

| State   | Professional/technical/managerial (%) | Clerical (%) | Sales and services (%) | Skilled manual (%) | Unskilled manual (%) | Agriculture (%) | Other (%) |
|---------|-------------------------------------|-------------|------------------------|--------------------|----------------------|-----------------|----------|
| Adamawa | 1.0                                 | 1.0         | 36.1                   | 0.2                | 0.0                  | 61.8            | 0.0      |
| Bauchi  | 2.1                                 | 0.3         | 75.0                   | 9.2                | 0.0                  | 13.2            | 0.3      |
| Borno   | 4.1                                 | 1.8         | 55.6                   | 20.4               | 0.0                  | 18.1            | 0.1      |
| Gombe   | 3.0                                 | 0.7         | 63.6                   | 13.2               | 0.0                  | 16.9            | 2.6      |
| Taraba  | 3.4                                 | 1.0         | 53.8                   | 0.1                | 0.0                  | 41.8            | 0.0      |
| Yobe    | 1.0                                 | 0.5         | 52.7                   | 3.4                | 0.0                  | 42.4            | 0.0      |
Risk perception describes belief about potential harm. It concerns how an individual understands and experiences a phenomenon. Menon, Raghubir & Agrawal (2001:2) define risk perception as “the perception of the subjective likelihood of the occurrence of a negative event related to health for a person or group of people over a specified time period”. Most studies of risk perception seek to provide a clearer understanding of the ways in which people form judgments about the challenges they face, with the aim of improving the communication of risk information between technical experts, politicians and the general public (Wilkinson, 2001).

Risk is perceived not solely by technical parameters or probabilistic numbers, but also in the psychological, social and cultural context. Therefore, individual and social characteristics form our risk perception and influence the way we react towards risks (Schmidt, 2004). Slovic & Peters (2006) also state that in the modern world, risk is perceived and acted upon in two fundamental ways—risk as feelings and risk as analysis: “Risk as feelings refers to our instinctive and intuitive reactions to dangers. Risk as analysis, brings logic, reason and scientific deliberation to bear on risk assessment and decision making” (p. 322).

Sociological and anthropological studies have shown that perception and acceptance of risk have their roots in social and cultural factors. For instance, Short (1984), cited in Slovic (1987), argued that response to hazards is mediated by social influences transmitted by friends, family, fellow workers or even respected public officials. Following this, in most cases, risk perceptions are formed as part of the rationale for one’s own behaviour. In addition, Douglas & Wildavsky (1982) assert that people, acting within social groups, usually downplay certain risks and emphasize others as a means of maintaining and controlling the group. This is because people do not exist

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Table 6. Employment status of women in the North-Eastern states of Nigeria. (Derived from NDHS 2018)

| State       | Employed in the 12 months preceding the survey (%) | Not employed in the 12 months preceding the survey (%) |
|-------------|---------------------------------------------------|-------------------------------------------------------|
|             | Currently Employed | Not currently employed |                                        |
| Adamawa     | 61.0               | 4.2                     | 34.8                                    |
| Bauchi      | 63.1               | 4.5                     | 32.5                                    |
| Borno       | 47.8               | 2.8                     | 49.4                                    |
| Gombe       | 43.4               | 1.7                     | 55.0                                    |
| Taraba      | 76.5               | 2.0                     | 21.5                                    |
| Yobe        | 71.3               | 1.9                     | 26.7                                    |
in social and cultural vacuums, and, therefore, decisions about risk and management of risk are socially embedded, shaped by culturally based ideas about the state of the world, what the world consists of, and how it works.

According to Agbaje, Agu & Osakwe (2015) harmful traditional practices are still prevalent in different cultural backgrounds in Nigeria, with attendant health risk for girls and women. The perception of the risks associated with these practices may assist in their eradication or perpetuation. As such, interventions such as public health promotion activities should be carried out for girls and women, particularly in rural communities.

**Theoretical Framework**

The Information Motivation and Behavioural Skills (IMB) Model is used as a framework for analysis in this study. The IMB Model postulates that health-related information, motivation and behavioural skills are important determinants of whether to perform a health behaviour (Fisher, Fisher & Harman, 2003). Hence, if people are well-informed, motivated to act, and have the skills and confidence to act, they are more likely to initiate and maintain health-promoting behaviours that may produce positive outcomes.

Information is the first construct and is directly related to preventive behaviour. The more information a person has, the greater the likelihood that he/she will indulge in preventive behaviour. Information, therefore, is the basic knowledge about a health condition. The second construct is motivation. Motivation here is of two types: (a) personal motivation to practice preventive behaviours, such as attitudes toward practicing specific preventive actions and (b) social motivation to engage in preventive behaviour, such as having perceptions of social support. The third construct of the IMB model is behavioural skills. This refers to an individual’s objective ability and self-efficacy in performing the behaviour. Self-efficacy is the confidence that a person has in his/her ability to perform a given behaviour in the immediate (Sharma, 2012).

The IMB model posits that performing a health promotion behaviour is a function of the extent to which an individual is well informed about the behaviour (e.g. has positive personal beliefs and attitudes towards the behaviour or outcome, and social support for the behaviour), and has the requisite skills to execute the behaviour and confidence in their ability to do so across various situations (Fisher & Fisher, 2000).

Essentially, one who is well informed and motivated is thought to develop and employ the skills necessary to enact the behaviour of focus and is likely to reap greater health benefits (Fisher, Fisher & Harman, 2003). Therefore, in order to adopt
prevention behaviour, people must have information that will translate easily into action, motivation to act, and skills to perform the behaviour. This study therefore assumes that provision of relevant information and creating the necessary awareness regarding harmful cultural practices relating to maternal health, or more broadly to women of childbearing age, will help a great deal in curbing such practices. The focus here is on factors that contribute to higher maternal mortality rates in rural areas of Bauchi state in northern Nigeria in particular but may be instructive for other parts of Nigeria in general.

**Methodology**

A Focus Group Discussion conducted with a population consisting of women of childbearing age (15 – 49 years) from the rural areas of Bauchi state was adopted as the research method in this study. Bauchi state has 20 Local Government Areas, namely: Alkaleri, Bauchi, Bogoro, Dambam, Darazo, Dass, Gamawa, Ganjuwa, Giade, Itas/Godau, Jama’are, Katagum, Kirfi, Misau, Ningi, Shira, Tafawa Balewa, Toro, Warji and Zaki.

Stratified Sampling was performed on the basis of Bauchi state’s three senatorial districts (Bauchi Central, Bauchi South and Bauchi North), for selection of areas to study. Using the findings of the NEHSI (2010) study, regarding the percentages attained by each local government area in terms of accessing maternal health information through the mass media, two local governments were selected from each of the senatorial districts, making a total of six (6) local government areas picked. As the researcher required liaison with facilitators conversant with the areas, who could create links that could expedite respondents’ acceptance of the researcher and the research exercise, the convenience sampling technique was employed in the selection of the communities. Mindful of the security situation in the North Eastern Part of Nigeria, which contributes to people’s scepticism of strangers, acceptance is necessary in this study. Two communities were selected in each of the six local governments chosen, making a total of twelve (12) communities, thus: Zungur, Sabon Gida, Anguwan Tsamiya, Burga, Sabuwar Kariya, Lamba, Kurduba, Sarma, Garanya, Kwayanti, ‘Yangamai and Gongo. One Focus Group Discussion was conducted in each of the 12 communities selected in the year 2016.

**Findings and Discussion**

Twelve Focus Group Discussion (FGD) sessions were held, one in each of the twelve communities sampled for this study. The FGD sessions were held with women of childbearing age (between ages 15–49). Each group consisted of between 9–12 women. Findings of the sessions are presented as aggregate views of the groups. The aggregate findings are presented and discussed under the following headings:
a) Prevalent Cultural Maternal Health Practices

Some cultural maternal health practices were discovered to still be prevalent in the study area. The practices are categorized into three stages that characterize maternity, namely, during pregnancy, at the time of childbirth, and in the period immediately after delivery (post-partum).

Pregnancy Practices

1. Consumption of herbs: This is a medicinal requirement for every pregnant woman. Herbs that are consumed aim at reducing excessive sickness for the pregnant woman. Some are believed to guard against the baby contracting shawara, understood as jaundice. Also, from the seventh month of pregnancy, the woman is encouraged to consume herbs until she delivers.

2. Food taboos are highly prevalent in all the communities studied, and are adhered to strictly because of certain beliefs that are associated with them. In the study area, the following foods are avoided during pregnancy:

   (i) Chicken: It is believed to be a factor that causes jaundice, which is called shawara, koriya or bayamma in the local dialect.

   (ii) Sweet foods such as sugarcane and sugar in general, sweet potatoes, honey, and dates, or drinks, are a taboo for the pregnant woman. Sweet foods are believed to cause complications for the woman, especially during labour.

3. The pregnant woman is also encouraged and expected to engage in rigorous domestic chores; it is believed this will ease labour pains and rigours experienced at the time for delivery. A vocal woman in one of the sessions specifically observed that rashin motsa jiki ta hanyar yin daka ko surfe kan sa mace ta galabaita a lokacin haihuwa saboda rashin karfi, meaning: lack of heavy domestic chores during pregnancy usually makes a woman very weak during labour because of lack of strength [stamina]. The pregnant woman is therefore not encouraged to rest much or be idle.

Childbirth Practices

1. The practices found to be culturally prevalent among women in the study area are presented in four clusters according to critical stages during childbirth. The first of these are the practices observed when the delivery takes place at home. In the
area of study, there is a cultural preference expressed in the posture for delivery. This is usual for childbirth that occur in homes. The reasons given by respondents, such as the posture for delivery, are cultural. Deliveries that take place in the hospital usually require women to lie down. Most women in the study identified this as a factor that puts them off from going to the hospitals for delivery. They said the lying position used in the hospital delivery is not conducive for them. They preferred to squat as they do during home delivery. According to one of the respondents, haihuwa a tsugunne yafi sauki da sutura, that is the squatting position, is easier and more secretive. Most women in the study identified this as a factor that puts them off from going to the hospitals for delivery.

2. Delivery alone at home is another cultural preference. According to the respondents, delivery at home is better. Specifically, a respondent in one of the groups observed that haihuwa a gida yafi, meaning, delivery at home is better. When asked why, she replied that: hakan yafi sirri da kuma rufin asiri, meaning that it fosters greater privacy and ensures secrecy. Delivery in the hospital [with medical teams consisting of strangers] makes it difficult to maintain such privacy. Privacy in circumstances such as childbirth is an attribute that is highly encouraged among the Hausa people. With home delivery, the pregnant woman is left to deliver all by herself, alone. In an instance where she encounters difficulty, the woman can alert one or two persons to assist and monitor her. As noted, it is also common practice for women in the study areas to deliver alone. Delivering alone is usually a mark of bravery; the woman who delivers unaided is usually regarded favourably and held in high esteem by her husband, in-laws and family members. Such women are known as Jaruma, meaning, brave woman comparable to one who had fought gallantly in battle.

3. Removal of the placenta is another birth stage where examples of traditional practices are observed. In cases where the placenta does not come out as expected after delivery, there are certain practices which the elderly women have found to be effective in aiding its ejection. Prominent amongst them are putting wooden ladle (muciya) in the mouth of the woman who is delivering. This induces the retching motion in the woman. As she tries to vomit, she is also pushing hard as if to empty her bowels, and this way, the placenta is delivered. This is the most common practice in these localities - the most relied upon as a first step in remedying the problem.

Another remedy typical to this group of people is the addition of peppers to the hot charcoal for the fire made to warm the woman. The peppers infuse the smoke which she inhales. This is meant to make the woman sneeze vigorously. The sneezing motion makes her push harder till she delivers the placenta. In yet another traditional remedy for dislodging the placenta, the woman is made to squat while another
woman holds and shakes her vigorously for the placenta to be forcefully ejected. This is referred to as *Jijjiga* in local dialect, meaning, to shake vigorously.

4. The fourth practice observed at this stage in the birth process is the cutting of the umbilical cord. This is done mostly by assistants such as a Traditional Birth Attendant or a co-wife. The cord is cut and tied with a rope. Those assisting in this direction do so based on direct experience they have acquired, which provides the knowledge of how this practice should be performed.

**Post-Partum Practices (*Jego*)**

Post-partum period, known as *jego* in the Hausa dialect, is the 40–42 day period immediately after delivery. In this period, the nursing mother abides by certain culturally assigned practices. These are discussed below.

1. **Expressing breastmilk to expel colostrum.** Draining out the colostrum from the breasts of nursing mothers is common practice in all the areas of study. The first breast milk, which is usually yellowish in colour, is an indication of the presence of colostrum, which, medically, is regarded as being beneficial to the child. However, in the study area, colostrum is considered dirty and harmful to the baby. It is believed that if taken by the infants it could purge them. The newly delivered mother is therefore directed to wash her breast thoroughly, and squeeze out the first milk, which is then thrown away. This practice is detrimental because colostrum has been medically certified to be beneficial to the health of the newly born baby.

2. **Hot Water Bath (*Wankan Jego*).** It is general practice that the nursing mother must bath with hot water infused with herbal leaves such as those from the Neem tree. These baths must be had daily for at least 40 days; the standard period is 42 days. During these baths, injuries, such as tears which were encountered during delivery are treated with the hot water and local soap (*sabulun salo*). In so far as the water is not excessively hot as to trigger high blood pressures or cause injury to the nursing mother, this practice is in tandem with modern maternal health practices. However, the practice amongst these women is that the water must be very hot. Though it is prevalent, some women manage to get exempted from this practice - usually with strong reservations. In fact, certain complications such as the swelling of the nursing mother’s body are associated with inadequate rigour or no observance of the hot water baths. A woman believed *rashin wanka da ihashshen ruwa mai zafi sosai yakan sa mace kumburi*, that is, lack of bathing with enough and very hot water makes the woman’s body to swell up. Also, for the entire confinement period, the woman remains in her dwelling (a room or house). It is believed that unnecessary exposure could harm the nursing mother or her child.
3. Food Taboos: As is the case during pregnancy, there are food taboos imposed on women during the post-partum period. Certain foods are also considered harmful and therefore, forbidden for the nursing mother. Prominent amongst the foods forbidden are chicken and food high in sugar content. Just as the eating of chicken is discouraged during pregnancy, it is discouraged during the post-partum period as it may still affect the baby, with effects typically manifesting as jaundice. Sweet foods are also discouraged for nursing mothers, especially in the early stages of the post-partum period. This is to prevent the contamination of the breast milk. It is believed that sweet foods and drinks can make the breast milk watery, which can subsequently cause the child to contract dysentery. However, the nursing mother is encouraged to consume foods that are hot as well as peppery, to heal the wounds of the womb.

The findings of this study reiterate the position of Shamaki & Buang (2014), who posited that tradition-inspired practices and norms such as unattended labour and delivery, low level of education, hot bath (wankan jago) during new birth, use of herbs, and forced/early marriage play significant roles in maternal health, and are believed to account for high rates of maternal mortality in northern Nigeria.

b. Mass Media Exposure

Although women in most parts of the study area were found to have been exposed to the mass media, this exposure was minimal because they were not exposed to multiple mass media channels. This corroborates the assertion that “men are more likely to be exposed to each type of mass media than women” (NDHS, 2013:39). The situation had not changed much in 2018. Specifically, of the six local government areas covered, women in five local government areas are exposed to the mass media, while women in one local government area (Giade) have minimal or low exposure. It was observed that the locations visited in this local government are more rural than all other locations for the study. As such, one may conclude that this local government is more rural, and therefore lacks basic social amenities more than other local government areas in the state. Radio is the most popular medium of exposure for those who are exposed to the mass media in this area. There are several reasons outlined for these which include the following:

- The audience are not literate; hence, they cannot read messages in newspapers or magazines, or even on posters.

- Television signals do not reach their localities, and even if they do, the audience do not have television sets.

- Radio can be listened to while doing house chores.
Economic factors and lack of interest were the major factors mentioned as being responsible for the relevant respondent’s lack of exposure to mass media. Most of the women in this category stated that their access to radio is minimal since the radio sets are owned by the men (their husbands). This may be because “men in northern Nigeria are considered leaders, bread winners, and the authority within the family, community, and society… women are therefore, highly dependent on their husbands” (Sinai et al, 2017:100).

Table 7. Breakdown of media use patterns of women in North-Eastern states of Nigeria. (Derived from NDHS 2018)

| State    | Newspaper (%) | TV (%) | Radio (%) | All three (%) | None (%) |
|----------|---------------|--------|-----------|---------------|----------|
| Adamawa  | 0.9           | 18.6   | 14.2      | 0.7           | 75.0     |
| **Bauchi** | **2.2**       | **10.4** | **28.1**  | **1.1**       | **67.8** |
| Borno    | 2.2           | 18.4   | 13.3      | 1.4           | 76.8     |
| Gombe    | 4.0           | 14.5   | 29.7      | 3.5           | 67.4     |
| Taraba   | 1.0           | 18.2   | 5.2       | 0.3           | 78.8     |
| Yobe     | 4.0           | 13.7   | 17.6      | 1.0           | 72.2     |

Table 8. Prevalence of internet use of women in North-Eastern states of Nigeria. (Derived from NDHS 2018)

| State   | Ever used the internet (%) | Used in the past 12 months (%) |
|---------|-----------------------------|-------------------------------|
| Adamawa | 6.8                         | 6.6                           |
| **Bauchi** | **3.4**                    | **2.9**                       |
| Borno   | 11.5                        | 10.5                          |
| Gombe   | 4.8                         | 4.5                           |
| Taraba  | 6.6                         | 5.8                           |
| Yobe    | 3.0                         | 2.8                           |
Table 9. Frequency of use for respondents with internet access. (Derived from NDHS 2018)

| State     | Almost every day (%) | At least once a week (%) | Less than once a week (%) | Not at all (%) |
|-----------|----------------------|--------------------------|---------------------------|---------------|
| Adamawa   | 43.5                 | 36.8                     | 19.8                      | 0.0           |
| **Bauchi**| **47.5**             | **29.1**                 | **15.6**                  | **7.8**       |
| Borno     | 64.2                 | 14.7                     | 15.7                      | 5.4           |
| Gombe     | 50.1                 | 38.8                     | 11.1                      | 0.0           |
| Taraba    | 52.4                 | 30.1                     | 16.1                      | 1.4           |
| Yobe      | 32.2                 | 43.5                     | 24.3                      | 0.0           |

Those respondents who are exposed to the radio from time to time were able to identify health programmes in which maternal health issues are discussed. The following are programmes which respondents mentioned:

*Lafiya Jari* - literally means ‘health is wealth’. This thirty (30) minute programme is supported by USAID in partnership with Bauchi State government. It focuses mainly on maternal and neonatal health issues. It is broadcast on the *Bauchi Radio Corporation (BRC)*, a state-owned radio station that operates on the Medium Wave (MW) band. The programme is broadcast on Tuesday mornings with a repeat broadcast on Thursday afternoons. *Lafiya Jari* is a recorded radio magazine programme that features experts in the areas of maternal and child health serving as discussants.

*Ya Take Ne?* – literally means ‘How is it’? It is a BBC medical action partnership programme that tries to support maternal health, women empowerment, domestic conflict resolution and promotion of gender parity issues. It is a radio magazine programme with a light drama segment. This thirty (30) minute programme is aired on Saturday evenings on the Frequency Modulation (FM) station of the Bauchi state owned radio known as BRC II.

*Haihuwa Lafiya* – literally means ‘safe delivery’. The programme, sponsored by Jigawa State Ministry for Women Affairs and Social Development, aired on *Radio Dutse*, a radio station owned by Jigawa state government and located in the state capital city, Dutse. It is also on *Freedom Radio, Dutse* (a privately-owned radio station also located in the state capital city, Dutse). As Jigawa is a neighbouring state to Bauchi, broadcast signals from Jigawa reach Bauchi, and vice versa, due to the close proximity of both states. The content of *Haihuwa Lafiya* focuses majorly on improving maternal health. It is a discussion programme targeted at women, interspersed with
some indigenous musical interludes. The thirty (30) minute programme and is aired twice a week on both stations.

This pattern of exposure, where majority of respondents are exposed to health messages through only one mass medium (radio), reflects awareness of the weak impact of mass media in the study areas. Evidently, the respondents’ level of exposure to other mass media messages is low in these communities. Yet, even with the use of radio, the mass medium that the women are exposed to the most, respondents in the FGDs still testified that there were no messages that specifically target cultural practices relating to maternal health.

However, besides the mass media (radio), there are other means through which women in the study areas encounter modern maternal health messages. Respondents who visit the health facilities for ante-natal care, which they rarely do, acknowledge that they come across maternal health messages through posters provided at the health facilities. There are such facilities in all the local governments; however, the women confirm that they rarely visit the health facilities, except during emergencies. Also, in eight (8) of the 12 locations used for this study, respondents mentioned another source of modern maternal health message—the Nigeria Evidence-Based Health System Initiative (NEHSI) team which visited the women frequently. The women were enlightened about aspects of maternal and child health during such health visits. Specifically, respondents from Garanya and Kwayanti Communities attested to having watched the NEHSI documentary drama which sought to discourage pregnant women from engaging in hard labour. They recalled that it also addressed issues of access to potable water and sanitation.

In nine (9) of the 12 communities for this study, respondents also mentioned the efforts of the Targeted States Impact Project (TSHIP) volunteers who visit them from time to time to address issues of maternal and child health. Some respondents also testified that they had been to the hospital once or twice due to certain complications of pregnancy, and childbirth and had come across posters during such visits. They further confirmed that they relied on visual elements of the posters to interpret the messages. Therefore, for this group of people, messages on maternal health, are encountered accidentally, and not as a matter of choice or interest.

c. Risk Perception

Findings from the study show that generally there is low risk perception among the women regarding the cultural practices on maternal health prevalent in their communities. For example, regarding hot water bath, most women are of the belief that refusing to do it could lead to sickness. Women in eleven (11) of the twelve FGD sessions believed that the nursing mother’s failure to have hot water baths results in
her body swelling. Prolonged labour as well as delivering the baby alone are seen as signs of bravery (Jarumta) leading to an increase in the woman’s respect. Similarly, home birthing is perceived as something that could ease the trauma of delivery; it is considered a factor that could give the woman strength during labour. These practices are risky since they fail to consider the likely health implications that could be encountered in the birthing process in the event of emergencies, such as rupturing of the uterus.

The risk perception exhibited by the women interviewed in this case study conforms to the theoretical descriptions provided by Schmidt (2004), Douglas & Wildavsky (1982), and Schiavo (2007), particularly in the way social characteristics have influenced the perpetuation of health practices. Some of the factors that promote this low-level risk perception are informed largely by cultural norms and socio-economic structures:

i. Risk perception is low because of the prevalent belief in the efficacy of the practices. Such beliefs are so strong that they go unquestioned. For example, most women believe that bathing with very hot water during the post-partum period gives the woman additional strength and health.

ii. The highly patriarchal Hausa society is another factor that has influenced low-level risk perception. In most cases, the pregnant woman or nursing mother needs the consent of her husband in enacting decisions, including in matters relating to her health. As such, these decisions are subject to other considerations of the patriarchal system. It is often easier to adopt cultural practices or remedies that are readily available at home or nearby locations than it is to wait for the consent of a man, especially if he is seldom available, or where the women are in seclusion as expected due to prevalent customs to which they are subjected. Even when they are around, some men may not consent to requests that contemplate adoption of modern remedies that are not readily available or easily accessible. There may be other reasons for this as will be discussed below.

Economic factors have been found to obstruct the adoption of modern health practices. Poor finances contributed to the prevalence of some of the noted practices. Most of the women are economically dependent on their husbands for everything that they may need. Consequently, more pressing household needs take priority over those specific to the women—certain needs, such as good nutrition and ANC visits, are regarded as luxury and often forfeited.

Absence of, or poorly equipped, health facilities in most of the areas visited is another factor that has contributed to the low-level risk perception observed. Poorly equipped and poorly resourced health facilities, those without adequate supply of trained staff,
were identified by respondents as one of the reasons for their adherence to traditional maternal health practices. In fact, in some of the places, there were no health facilities that the women could easily access in times of need. The added ordeals experienced in attempting to access modern facilities, such as enduring the rigours of the poor road networks and transportation systems, contribute to the belief that modern health remedies are more difficult than traditional remedies.

Pregnant women, children and sick people are conveyed to hospital on donkeys in Bauchi communities (photo from Daily Times Nigeria, 26/12/2019)

Accessed online https://www.pulse.ng/news/local/bauchi-communities-where-pregnant-women-sick-people-are-taken-to-hospitals-on-donkeys/p0yzfrd

Illiteracy is another critical factor that affected the risk perception of the women. Most women in the study area have low or no formal education. As a result, there is a general belief amongst respondents that they should be excluded from modern health remedies since these are meant for people whom they refer to as Yan boko, meaning, the educated ones, whom they consider to be the privileged group capable of accessing the modern remedies easily. Their ignorance was manifested in the fatalistic belief that whatever is destined for one by God must be; once it has been destined, fatalities will occur even if one goes to the modern health facility and embraces modern remedies. According to Shamaki & Buang (2014), such practices (cultural) are predominant among women with low education attainment.

Minimal exposure to modern health information further compounds the situation. There is minimal exposure to modern health campaigns or messages especially from the mass media, among all respondents in the study area. Messages that specifically
address cultural practices that place maternal health at risk seem to be lacking, and in general, the few relevant messages available are either not accessed, or not listened to. This brings to fore the argument of the IMB model, which postulates that health-related information, motivation and behavioural skills are important determinants of whether to perform health behaviour (Fisher, Fisher & Harman 2003). People who are not well-informed are less likely to be motivated to act appropriately; they may not have the skills and confidence to initiate and maintain health-promoting behaviours.

**Conclusion**

The findings of this study indicate that there are harmful cultural practices in maternal health that still persist among Hausa women in rural areas of Bauchi State, despite the availability of modern health messages obtained through the mass media and alternative sources like Non-Governmental Organizations.

People often rely on the mass media for their health-related information. This is because exposure to information from the mass media can increase their knowledge and awareness of new ideas, bring about social changes and opportunities, as well as affect their perceptions and behaviour, including those related to health (NDHS, 2013). Mass media also have the potential to perform valuable health-education/promotion functions. They can facilitate positive health goals with short, intermediate or even long-term effects on audiences. Such goals could be to expose audiences to health concepts, create awareness and impart knowledge, correct erroneous beliefs, effect changes in attitudes or behaviour, or even changes in perceptions of social norms.

While the mass media can play an important role in disseminating health information to the public, the reception and acceptance of this information depends on the demographic group. Mass media messages or campaigns frequently compete with factors such as social norms and behaviour. Therefore, standardised messages might not be effective in reaching culturally diverse audiences. Also, important to note is the fact that media campaigns might address behaviours that audiences lack the resources to change. As such, it is recommended that within the cultural context of the Hausas in northern Nigeria, especially in Bauchi state, mass media organisations should be encouraged to prioritise maternal health issues when packaging health promotion programmes. Specifically, programmes should be appropriately designed and packaged to focus on the harmful cultural practices prevalent in the target communities with a view to reducing maternal mortality rates.
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