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PREVALENCE OF MATERNAL MORTALITY AND CULTURAL BARRIERS AFFECTING WOMEN'S UTILISATION OF MODERN MATERNAL HEALTHCARE SERVICES IN NORTH-WEST NIGERIA

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Abstract: **Background:** Cultural and religious barriers continue to impede women's access to modern maternal healthcare services, limiting the impact of policy and infrastructure improvements. This study, therefore, examined the prevalence of maternal mortality and the extent to which cultural practices affect women's utilisation of modern maternal healthcare in North West Nigeria. **Methods:** A descriptive survey design was adopted, targeting women of reproductive age across seven states in the zone. Using a multistage sampling method, 210 participants were selected, and data were collected using a validated semi-structured questionnaire, the reliability of which was confirmed by a Cronbach's Alpha coefficient of 0.87. Data were analysed using descriptive statistics. **Results:** Findings revealed that maternal mortality remains alarmingly high, with over 96% of respondents acknowledging maternal deaths in their communities. About 32.1% reported more than ten maternal deaths within the past year, and most communities lacked accessible emergency obstetric services, with 32.1% of respondents living more than 20 km from healthcare facilities. Overall, 61.7% of respondents perceived cultural practices to influence healthcare utilisation to an average extent, while 24.9% reported a great extent of influence. **Conclusion:** The study concluded that maternal mortality in North West Nigeria remains a major health crisis sustained by entrenched cultural norms, gender inequality, and limited healthcare access. The study recommends expanding rural healthcare infrastructure, providing free or subsidised maternal care, and implementing awareness programmes that challenge harmful cultural beliefs and encourage men's participation in maternal health decisions.

Keywords: *Maternal mortality, cultural barriers, modern healthcare utilisation, women's health, gender inequality*

I. INTRODUCTION

Maternal mortality remains one of the most pressing public health challenges globally, particularly in developing regions where cultural, economic, and structural barriers continue to undermine maternal health outcomes. Despite global advancements in healthcare, the prevalence of maternal deaths remains disproportionately high in low- and middle-income countries [1]. In 2023, an estimated 260,000 maternal deaths occurred worldwide, equivalent to 712 deaths every day. However, this represents a 40% reduction since 2000; over 90% of these deaths still occur in low- and lower-middle-income countries, with sub-Saharan Africa accounting for the largest share of the global burden [1]. Nigeria remains the country most affected, contributing the single largest share of global maternal deaths and recording a maternal mortality ratio estimated at 993 per 100,000 live births in 2023, the highest of any country in Africa [2]. Within the country, the North West region continues to bear a disproportionate share of this burden: the last nationally representative survey to publish a maternal mortality ratio put the national figure at 512 deaths per 100,000 live births, with the northern zones consistently reporting the highest regional ratios [3]. This alarming figure underscores the urgent need to investigate the cultural and behavioural determinants that continue to impede the utilisation of modern maternal healthcare services in the region.

Maternal deaths are largely preventable through timely access to antenatal, delivery, and postnatal care services [4]. Yet, in many communities within North West Nigeria, women's health-seeking behaviour remains influenced by a complex interplay of cultural traditions, religious interpretations, and gender dynamics. The majority of maternal fatalities occur during the intrapartum and immediate postpartum periods, primarily due to complications such as haemorrhage, hypertension, and sepsis, conditions that could be effectively managed with adequate healthcare [1]. However, most deaths occur at home,

particularly among women in rural areas, reflecting limited access to or utilisation of modern healthcare facilities. As Sinai et al. [5] observed, deep-rooted patriarchal structures continue to dictate women's health choices, where seeking permission from husbands before using contraceptives or accessing healthcare remains a norm. Such cultural and gendered barriers render women powerless in making decisions about their reproductive health, perpetuating cycles of vulnerability and poor maternal outcomes.

Religion and cultural beliefs further compound the challenge. In the predominantly Islamic North West region, religious and cultural structures significantly shape maternal health behaviours [6]. While Islam promotes the sanctity of life, some interpretations of religious doctrine inadvertently restrict women's access to healthcare by discouraging consultations with male doctors or prioritising spiritual over medical interventions. This often results in delays in seeking timely obstetric care, increasing the risk of preventable maternal deaths. Husbands, who commonly serve as household decision-makers, reinforce these religious and cultural norms. When men uphold conservative views, women's ability to seek antenatal or emergency care becomes severely limited, reinforcing gender inequities in health access.

Cultural expectations surrounding fertility and family size also contribute to the high maternal mortality rates in North West Nigeria. In many rural communities, large families are considered symbols of social prestige and economic stability [7]. Consequently, women face immense societal pressure to bear multiple children, often with little or no spacing between pregnancies. Such practices increase the likelihood of complications like uterine rupture, unsafe abortion, and postpartum haemorrhage. In addition, male dominance in reproductive decision-making prevents women from adopting family planning methods that could safeguard their health. Gender inequality in decision-making and resource allocation exacerbates these challenges, with men prioritising expenditures unrelated to maternal health while women bear the brunt of its consequences.

Early marriage and adolescent pregnancy are other cultural factors significantly contributing to maternal mortality in the region. Felker-Kantor et al. [8] reported that in North West Nigeria, about 29% of adolescent girls have begun childbearing by age 19, exposing them to early pregnancies that often result in severe complications such as eclampsia, obstructed labour, and obstetric fistula. These early pregnancies occur before the reproductive system is fully matured, increasing the risks of both maternal and neonatal deaths. The persistence of this practice is often justified by cultural beliefs linking early marriage to family honour and moral preservation, thereby normalising health risks among young girls.

In addition, harmful traditional practices like female genital mutilation (FGM) and the reliance on Traditional Birth Attendants (TBAs) persist as major contributors to poor maternal health outcomes. Although FGM prevalence in West Africa is comparatively lower than in parts of East Africa, it remains a source of long-term complications such as obstructed labour and postpartum infections [9]. Similarly, TBAs, who are often respected figures within their communities, lack the medical training necessary to manage obstetric emergencies [10]. Their continued patronage reflects a preference for culturally familiar, low-cost care over institutional healthcare. Husbands and elder women, including mothers-in-law, often influence these decisions, prioritising traditional norms over medical safety.

Dietary restrictions during pregnancy also represent a subtle yet significant cultural barrier to maternal health. In some communities, pregnant women are discouraged from consuming protein-rich foods like eggs and fish due to misconceptions about their effects on the unborn child [6]. Such practices contribute to maternal malnutrition and anaemia, which heighten the risks of preterm births and postpartum complications. These traditional norms, often enforced by older female relatives, demonstrate how cultural perceptions of pregnancy intersect with gendered power dynamics to perpetuate maternal vulnerability.

Addressing maternal mortality in North West Nigeria therefore requires a culturally sensitive and multi-pronged approach. Healthcare providers must engage directly with communities to dispel myths and promote evidence-based practices through culturally adapted health education [11]. Collaboration with religious and traditional leaders can help reinterpret cultural and religious norms in ways that prioritise maternal health and encourage the acceptance of modern healthcare services. Moreover, involving men in maternal health advocacy is critical, as they hold substantial influence over household decisions related to healthcare utilisation. Encouraging joint decision-making between spouses and integrating male-focused health education can shift patriarchal attitudes that limit women's autonomy.

Ultimately, reducing maternal mortality in North West Nigeria demands more than improved medical infrastructure; it requires transforming the socio-cultural landscape that dictates women's health choices. Bolarinwa et al. [11] emphasised that addressing inequalities in healthcare access involves community engagement, culturally sensitive care, and changing behavioural patterns, attitudes, and community norms. Through strategic partnerships among healthcare providers, policymakers, and local stakeholders, it is possible to bridge the gap between traditional and modern healthcare, ensuring that every woman can exercise her right to safe motherhood, free from cultural constraints. Although previous studies have examined maternal mortality and healthcare utilisation in Nigeria, limited evidence exists regarding the combined influence of cultural barriers and maternal mortality experiences among women in North-West Nigeria. This study was therefore conducted to provide empirical evidence that may guide culturally appropriate maternal health interventions.

The study examined the prevalence of maternal mortality and cultural barriers affecting women's use of modern maternal healthcare in North West Nigeria. The specific objectives of the study are:

1. To determine the prevalence of maternal mortality among women in North West Nigeria.

2. To assess the extent of cultural practices on women's utilisation of modern maternal healthcare services in North West Nigeria.

II. METHODOLOGY

The study adopted a descriptive survey research design to investigate women's utilisation of modern maternal healthcare services in the North West geopolitical zone of Nigeria. The study population consisted of women of reproductive age across the seven states in the zone (Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto, and Zamfara), a zone that continues to report the lowest national coverage of antenatal care and skilled birth attendance [18]. A total sample of 210 women was determined using the Cochran sampling formula to ensure adequate representation.

A multi-stage sampling procedure was employed to enhance inclusivity and representativeness. At the first stage, three states were purposively selected based on high maternal mortality rates, cultural diversity, and availability of healthcare infrastructure. At the second stage, two Local Government Areas (LGAs) were selected from each of the three states using purposive sampling, one urban LGA and one rural LGA, to ensure that both settlement types were adequately represented. The selected LGAs were as follows: Sokoto North LGA (urban) and Tambuwal LGA (rural) in Sokoto State; Birnin-Kebbi LGA (urban) and Fakai LGA (rural) in Kebbi State; and Gusau LGA (urban) and Zurmi LGA (rural) in Zamfara State. This yielded six LGAs in total across the three states. At the third stage, two communities were selected from each LGA using simple random sampling, giving a total of twelve communities across the six LGAs. Within each community, households were selected using systematic random sampling, and in each household, the most senior eligible woman of reproductive age who provided informed consent was recruited.

Proportionate allocation was applied to distribute the total sample of 210 respondents across the three states and their respective LGAs, as presented in Table 1 below. Overall, 126 participants were recruited from urban LGAs and 84 from rural LGAs.

Table 1: Sample distribution across states, LGAs, and settlement types

State	LGA	Settlement Type	No. of Communities	Sample (n)
Sokoto	Sokoto North	Urban	2	42
	Tambuwal	Rural	2	28
Kebbi	Birnin-Kebbi	Urban	2	42
	Fakai	Rural	2	28
Zamfara	Gusau	Urban	2	42
	Zurmi	Rural	2	28
Total			**12**	**210**

Data collection relied on a semi-structured questionnaire designed to gather quantitative data from women, men, and healthcare providers. The instrument for women included three sections. Section A gathered socio-demographic information such as age, education, religion, marital status, ethnicity, and occupation. Section B examined the prevalence of maternal mortality in the North West region, while Section C focused on cultural practices influencing women's use of modern maternal healthcare services. This section contained 25 items rated on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree," with total obtainable scores between 25 and 125 points. The instrument's validity was established through face and content validation by experts in Nursing and Tests and Measurement, who assessed the questionnaire for clarity, relevance, and appropriateness. Their feedback guided necessary revisions to ensure accuracy and alignment with the study objectives. Reliability of the instrument was confirmed using the internal consistency method. Ten per cent of the sample size was tested outside the main study area, and the Cronbach Alpha coefficient obtained was 0.87, indicating high reliability and consistency of the questionnaire.

Data Collection Procedure: Before data collection, a one-day training session was held for the assistants to familiarise them with the study objectives, tools, and ethical considerations. Data collection was conducted directly by the researcher and six trained research assistants who obtained voluntary consent from participants over 6 weeks. The questionnaire was prepared in English. Face-to-face questionnaire distribution was conducted in participants' homes. Each questionnaire took approximately 15-20 minutes. Participants who could not read were assisted through verbal administration of the questionnaire in their preferred language. Completed questionnaires were reviewed for completeness and accuracy before being coded, cleaned, and entered into Microsoft Excel. The data were then exported to the Statistical Package for Social Sciences (SPSS) version 28 for analysis. Descriptive statistics, including means, standard deviations, and simple percentages, were used to address the research objectives, and results were presented in tables for clarity.

Ethical Considerations

Ethical approval was obtained from the appropriate Research Ethics Committee before commencement of the study. Informed consent was obtained from all participants, and confidentiality and anonymity were maintained throughout the study.

III. RESULTS

Table 2: Description of the socio-demographic characteristics of the respondents

Variables	Freq.	Percent (%)
Age		
18-25 years	14	6.7
26-35 years	40	19.1
36-45 years	67	32.1
46-55 years	69	33.0
Above 55 years	19	9.1
Educational Status		
No Formal Education	21	10.0
Primary Education	28	13.4
Secondary Education	65	31.1
Diploma/Certificate	78	37.3
Bachelor's degree	14	6.7
Postgraduate degree	3	1.4
Religion		
Christianity	17	8.1
Islam	172	82.3
Traditional	8	3.8
Other	12	5.7
Marital Status		
Single	46	22.0
Married	146	69.9
Divorced	1	0.5
Widowed	16	7.7

The socio-demographic data revealed that the majority of respondents were within the age range of 36–55 years (65.1%), indicating that most participants were mature adults likely to have significant reproductive and social experiences relevant to the study. In terms of education, most respondents had attained at least a secondary level of education, with 37.3% holding diploma or certificate qualifications and 31.1% having secondary education, suggesting a relatively educated population capable of understanding and engaging with health-related issues. The religious distribution showed that Islam was the predominant faith (82.3%), reflecting the religious composition typical of the North-West region of Nigeria, where the study was conducted. Additionally, marital status data indicated that the majority of respondents were married (69.9%), which aligns with the study's focus on maternal health, as married individuals are more likely to have direct experience with reproductive and maternal health services.

Table 3: Prevalence of maternal mortality among women in North West Nigeria

S/N	Items	Options	Freq	%
1	In your community, how many maternal deaths (women dying during pregnancy, childbirth, or within 42 days after delivery) have been recorded in the past year?	None	7	3.3
		1–5 cases	72	34.4
		6–10 cases	63	30.1
		More than 10 cases	67	32.1
2	How frequently do you hear about maternal deaths occurring in your locality?	Never	10	4.8
		Rarely (once or twice a year)	50	23.9
		Occasionally (every few months)	63	30.1
		Frequently (every month or more)	86	41.1
3	How many women in your household have experienced complications during pregnancy or childbirth in the last five years?	None	9	4.3
		1 woman	100	47.8
		2–3 women	39	18.7
		More than 3 women	61	29.2
4	How far is the nearest health facility that provides emergency obstetric care in your area?	Less than 5 km	40	19.1
		5–10 km	71	34.0
		11–20 km	31	14.8
		More than 20 km	67	32.1
5	How frequently do emergency maternal health services respond to pregnancy or childbirth-related complications in your community?	Never	29	13.9
		Rarely	58	27.8
		Sometimes	44	21.1
		Frequently	78	37.3

The data in Table 3 reveal a worrying level of maternal mortality prevalence among women in North West Nigeria. A significant proportion of respondents (32.1%) reported that more than 10 maternal deaths had been recorded in their communities within the past year, while 30.1% and 34.4% reported between 6–10 and 1–5 cases, respectively. This indicates that over 96% of respondents acknowledged at least one case of maternal death in their area, highlighting a high incidence rate. Furthermore, the frequency of maternal death reports substantiates this finding, as 41.1% of respondents stated that they frequently (every month or more) hear about such deaths, while 30.1% noted occasional reports. These figures suggest that maternal deaths are not isolated occurrences but rather frequent and recurrent events within many communities.

The accessibility and responsiveness of maternal health services further explain the high prevalence observed. Only 19.1% of respondents live within 5 km of a health facility offering emergency obstetric care, while a large proportion (32.1%) must travel more than 20 km to reach such services. This indicates a major geographic barrier to accessing timely maternal healthcare, especially in emergencies. Moreover, 41.7% of respondents reported that emergency maternal health services

either rarely or never respond to complications, suggesting inefficiency and limited availability of life-saving interventions. The data on pregnancy-related complications within households also reinforce this pattern, as 47.8% reported at least one woman in their family experiencing complications in the past five years, and nearly 30% reported more than three women affected. These findings collectively answer the research question by confirming that the prevalence of maternal mortality among women in North West Nigeria is alarmingly high, driven by frequent occurrences of maternal deaths, widespread pregnancy complications, poor access to emergency obstetric care, and inadequate responsiveness of health services.

Table 4: Cultural practices on women's utilisation of modern maternal healthcare services in North West Nigeria

S/N	Items	SA (%)	A (%)	N (%)	D (%)	SD (%)	Mean	S.D
1	Religious beliefs in my community discourage women from seeking modern maternal healthcare services.	40 (19.1)	99 (47.4)	47 (22.5)	23 (11.0)	0 (0.0)	3.75	0.89
2	Women in my community prefer prayer and spiritual interventions over hospital care during pregnancy and childbirth.	9 (4.3)	127 (60.8)	58 (27.8)	11 (5.3)	4 (1.9)	3.60	0.74
3	Religious leaders influence women's decisions to use or avoid modern maternal healthcare services.	19 (9.1)	83 (39.7)	84 (40.2)	23 (11.0)	0 (0.0)	3.45	0.81
4	Some religious groups in my community prohibit women from being attended to by male healthcare professionals during childbirth.	107 (51.2)	0 (0.0)	39 (18.7)	9 (4.3)	7 (3.3)	3.85	0.93
5	The use of family planning is discouraged in my community due to religious beliefs.	46 (22.0)	99 (47.4)	45 (21.5)	9 (4.3)	10 (4.8)	3.78	0.99
6	Women in my community are expected to have many children, which discourages the use of modern maternal healthcare services.	48 (23.0)	122 (58.4)	30 (14.4)	9 (4.3)	0 (0.0)	4.00	0.74
7	Seeking maternal healthcare services is perceived as unnecessary since childbirth is seen as a natural process in my community.	41 (19.6)	130 (62.2)	28 (13.4)	10 (4.8)	0 (0.0)	3.97	0.72
8	Frequent pregnancies due to cultural preference for large families increase maternal health risks but do not encourage modern healthcare use.	18 (8.6)	112 (53.6)	69 (33.0)	10 (4.8)	0 (0.0)	3.66	0.70
9	Women who limit their number of children using modern healthcare services face societal disapproval in my community.	17 (8.1)	81 (38.8)	59 (28.2)	52 (24.9)	0 (0.0)	3.30	0.94
10	The use of modern maternal healthcare services is seen as a way to control birth, which is culturally unacceptable.	14 (6.7)	69 (33.0)	98 (46.9)	17 (8.1)	11 (5.3)	3.28	0.90
11	In my community, husbands or male family members make the final decision on whether a woman can visit a hospital during pregnancy.	0 (0.0)	73 (34.9)	100 (47.8)	36 (17.2)	0 (0.0)	3.18	0.70
12	Women who seek maternal healthcare without their husband's permission may face consequences.	0 (0.0)	86 (41.1)	92 (44.0)	31 (14.8)	0 (0.0)	3.26	0.70
13	Limited access to education for women in my community reduces their knowledge and use of modern maternal healthcare services.	19 (9.1)	127 (60.8)	49 (23.4)	10 (4.8)	4 (1.9)	3.70	0.78
14	Women are expected to endure childbirth without medical interventions as a sign of strength.	39 (18.7)	100 (47.8)	50 (23.9)	8 (3.8)	12 (5.7)	3.69	1.00
15	The cultural belief that men should not accompany their wives to antenatal care discourages hospital visits.	39 (18.7)	106 (50.7)	44 (21.1)	15 (7.2)	5 (2.4)	3.76	0.92
						Total	**54.23**	**3.86**

Mean cut-off: 2.50

The data in Table 4 reveal that cultural and religious beliefs significantly influence women's utilisation of modern maternal healthcare services in North West Nigeria. The overall mean scores for all items were above the 2.50 cut-off, indicating general agreement among respondents that these cultural practices restrict access to modern healthcare. The strongest areas of influence include community expectations that women should have many children (Mean = 4.00), the perception that childbirth is a natural process that does not require medical intervention (Mean = 3.97), and the prohibition of male healthcare professionals attending to women during childbirth (Mean = 3.85). These findings suggest that deeply entrenched religious and cultural norms reinforce traditional gender roles and restrict women's autonomy in seeking professional care. Moreover, the discouragement of family planning due to religious beliefs (Mean = 3.78) further highlights how fertility ideals and moral expectations shape maternal health behaviour in the region.

Additionally, the results show that patriarchal structures continue to dominate maternal health decisions. For instance, the belief that husbands or male family members have the final say on hospital visits (Mean = 3.18) and that women may face consequences for seeking healthcare without their husbands' permission (Mean = 3.26) reflect gendered power imbalances that limit women's independence. Furthermore, societal disapproval of women who use modern family planning (Mean = 3.30) and the perception that endurance in childbirth signifies strength (Mean = 3.69) reinforce traditional ideologies that undermine maternal safety. Limited female education (Mean = 3.70) also emerged as a barrier, reducing awareness and informed decision-making regarding modern healthcare options. Collectively, these results indicate that cultural, religious, and gender norms intertwine to discourage hospital-based maternal care, underscoring the need for culturally sensitive interventions that promote women's empowerment and community-based education.

To summarise the extent of cultural practices on women's utilisation of modern maternal healthcare services in North West Nigeria, the mean and standard deviation values were used.

Low Extent: Mean − Standard Deviation = 54.23 − 3.86 = 50.37

High Extent: Mean + Standard Deviation = 54.23 + 3.86 = 58.09

Table 5: Summary of the extent of cultural practices on women's utilisation of modern maternal healthcare services

Level	Frequency	Percent
Low Extent (15.00 – 50.37)	28	13.4
Average Extent (50.38 – 58.08)	129	61.7
High Extent (58.09 – 75.00)	52	24.9
Total	**209**	**100.0**

The summary in Table 5 indicates that cultural practices exert a considerable influence on women's utilisation of modern maternal healthcare services in North West Nigeria. A majority of respondents (61.7%) perceived these cultural practices to affect women's healthcare utilisation to an average extent, while nearly one-quarter (24.9%) believed the impact was high. Only a small proportion (13.4%) reported a low extent of influence. This distribution suggests that although the influence of cultural practices varies across individuals, it remains generally substantial and pervasive in the region. The predominance of respondents acknowledging at least an average level of influence highlights how deeply rooted cultural beliefs, religious norms, and traditional gender expectations continue to shape women's health-seeking behaviours, thereby limiting their access to and acceptance of modern maternal healthcare services.

IV. DISCUSSION OF FINDINGS

The findings indicate that maternal mortality remains alarmingly high among women in North West Nigeria, largely due to inadequate emergency obstetric care, poor health service responsiveness, and frequent pregnancy complications. This finding is consistent with the study by Orjingene et al. [12], who found that maternal mortality in Northern Nigeria is among the highest in the country, primarily driven by preventable factors such as low antenatal care coverage, poor infrastructure, and delayed access to skilled birth attendance. Similarly, Ntoimo et al. [10] identified the continued reliance on traditional birth attendants over skilled personnel as a key contributor to high maternal mortality rates in rural communities. Furthermore, Oladipo and Akinwaare [13] reported that haemorrhage, eclampsia, and cardiovascular complications remain leading causes of maternal deaths, often worsened by delayed intervention. The present finding also aligns with the WHO and partner agencies [1], who established that maternal mortality correlates strongly with weak healthcare delivery systems and low socioeconomic development. However, Bolarinwa et al. [11] offered a more optimistic view, suggesting that improvements in maternal health outcomes are achievable through expanded health insurance, community engagement, and sustained policy commitment. The persistence of high mortality in North West Nigeria despite global advancements indicates deep-rooted systemic issues, including insufficient government funding and entrenched cultural barriers limiting timely access to care.

The findings reveal that cultural practices substantially affect women's utilisation of modern maternal healthcare services, as the majority of respondents acknowledged these practices to have an average to high influence. This aligns with Opara et al. [6], who noted that cultural and religious structures, particularly gender roles and faith-based prescriptions, often dictate women's health-seeking behaviours in Nigeria. Traditional beliefs, such as the reliance on spiritual healing and the preference

for home delivery, remain strong determinants of healthcare utilisation. Similarly, Elom et al. [14] found that religious ideologies and patriarchal expectations contribute to the rejection of modern maternal interventions like Caesarean sections. Furthermore, Oluwole et al. [15] observed that traditional birth attendants are still widely trusted because they align with community customs and provide culturally familiar, low-cost support. In contrast, Imo [16] argued that the extent of cultural influence is mitigated by women's decision-making autonomy, suggesting that greater autonomy and education can encourage more women to seek modern care. This is corroborated by evidence that household poverty-wealth status further shapes women's decision-making autonomy and their utilisation of reproductive and maternal health services in rural Nigeria [17]. Nonetheless, the prevailing impact of culture in North West Nigeria continues to limit maternal healthcare access, as many women defer health decisions to their husbands or elders.

V. CONCLUSION

The study concludes that maternal mortality remains a serious public health concern in North West Nigeria, largely exacerbated by the interplay of cultural, structural, and gender-based barriers. Women's access to modern maternal healthcare is significantly constrained by deep-rooted cultural norms, patriarchal values, and socioeconomic challenges that promote reliance on traditional practices over institutional medical services. Although awareness of modern maternal care is growing, utilisation remains inconsistent, reflecting the persistence of harmful cultural practices and gender inequality in healthcare decision-making.

VI. STUDY LIMITATIONS

This study employed a descriptive cross-sectional design, which limits the ability to establish causal relationships between cultural practices and maternal mortality. Data were obtained through self-report measures and may therefore be subject to recall bias and social desirability bias. In addition, the study was conducted in selected states of North-West Nigeria; therefore, the findings should be generalised with caution to other geopolitical zones of the country. Despite these limitations, the study provides valuable insights into the cultural factors influencing maternal healthcare utilisation among women in the region.

VII. RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made:

1. The government should improve healthcare infrastructure by building more maternal health facilities in rural and underserved areas, ensuring that women can access skilled care without the constraints of distance or transportation difficulties.
2. Economic barriers should be reduced by introducing subsidies or free maternal healthcare services for low-income families, enabling all women to receive antenatal, delivery, and postnatal care regardless of financial status.
3. Initiatives that enhance women's literacy, vocational skills, and financial independence should be prioritised to improve their autonomy in making informed healthcare decisions.
4. Community-based male engagement interventions, which have shown promise in improving demand for and utilisation of maternal and child health services elsewhere in northern Nigeria, should be scaled up across North West Nigeria [19].

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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