

**CULTURAL PRACTICES AND INFANT MORTALITY IN WAMMAKO LOCAL
GOVERNMENT AREA OF SOKOTO STATE**

BY

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CERTIFICATION

This research study has been read and approved as meeting the requirement of the Department of Sociology for the award of B.Sc. (Hon) in Sociology of the Faculty of Social Science, Usmanu Danfodiyo University, Sokoto.

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DEDICATION

This research is dedicated to the Almighty Allah (S.W.A) who has given me the opportunity to see the end of this research. And the completion of my four year degree programme of the faculty of social sciences, department of sociology Usmanu Danfodiyo University Sokoto.

Also, this research work is whole-heartedly dedicated to my parents. Alhaji Gatawa M.A. and my mum Mallama Rabi'at Abubakar Gatawa whose love and support both morally and financially has seen me through and would continue to see me through.

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ABSTRACT

Save the children initiative (2014), estimated general infant mortality rate to be 100 deaths per 1,000 live births for the 2011-2014 period (NPC, 2014). Regionally, south east, south west, north east and northwest have infant mortality rates of 74, 81, 129 and 139 deaths per 1,000 live births respectively. Indicating the highest concentration in the North West (NPC, 2014). This research examines if there is any relationship between some cultural practices and infant death in Wamakko Local Government Area. The town consist of 11 wards, in which six wards were selected out of the 11 wards. 100 women respondents were drawn on the basis of availability. The target population were married women who must have given birth at least once. The unit of analysis is married women. The research's critical variables are maternal rights, decision making, traditional circumcision and awareness. The type of data sought is quantitative (questionnaire). Simple percentage and chi-square in SPSS 20.1 version were used to test the hypothesis. Findings revealed that there is relationship between the levels of traditional circumcisions carried out by traditional experts and the higher level of infant mortality. And also, there is relationship between higher mother's participation in decision making and the lower level of infant mortality in Wamakko. The research recommends that there should be proper awareness of the negative impact of some of these cultural practices on infant mortality should be created. The restrictions of maternal right should be reviewed and the female should be allowed more opportunity in decision making within the home.

CHAPTER ONE: INTRODUCTION

1.0 BACKGROUND TO THE STUDY

Infants and child mortality rate is an accepted global indicator of the health and socioeconomic status of a given population (WHO; 1981, 1990). Despite the arguments that the determinants of infant and child mortality were extensively investigated and that there was a continued decrease in mortality rates among children and infants in most of the developing world, these reductions are not impressive when compared to other developed countries like Japan, France, Spain and United States. In Nigeria, factors such as economic and political policies had been associated with infant mortality, but some researchers explained that, most of the reasons for the death of infants are deeply rooted in people's beliefs and attitudes concerning child care and behavioural practices in relation to health strategies (Save the Children, 2014).

The perceptions and attitudes of people influence the way they perceive and react to health related issues, as such any health development initiative that does not take into Account cultural issues might prove ineffective in view of this, the present study is designed to find out the relationship between cultural practices and infant mortality in Wammako community Sokoto State.

Statistic from the save the children organization, an international non-profit group, has revealed that almost 800,000 Nigerian children die every year before their fifth birthday, making Nigeria the country with the highest number of new born death's in Africa (Save the

Children, 2014). The group said majority of deaths under the age of five particularly in the Northern part of the country are due to treatable and preventable diseases.

The rate of infant mortality (probability of dying before the first year of life), varies globally, for instance, in 2012 some of the developed countries like Japan, France, Spain and United states had an infant mortality rate of 2,4,4 and 6 death per 1,000 live births respectively (World Population Data Sheet, 2012). In 2013, Japan France, Spain and United states, infant mortality rate declined to 1.3, 3.7, 3.8 and 5.5 respectively (world development indicators, 2013). In 2014, Japan France, Spain and United states, Infant mortality rate also declined to 1.6, 2.4, 3.6 and 5.3 respectively (World development indicators, 2014) But huge disparities exist within ethnic and racial groups in some of these countries.

In 2012, less developed countries like Benin, Kenya, Nigeria and South Africa had an infant mortality rate of 62, 52, 82, and 35 deaths per 1,000 live births respectively (World development indicators, 2012). In 2013 Benin, Kenya and Nigeria's Infant mortality rate declined to 60, 50, and 79 deaths per 1,000 live births respectively (World population data sheets, 2013). In 2014, Kenya, Nigeria and South Africa still retained their infant mortality levels, only Benin declined to 56 deaths per 1,000 live births(World Population Data Sheet, 2014).

1.2 STATEMENT OF THE RESEARCH PROBLEM

In every culture, important practices exist which celebrate life-cycle transitions, perpetuates community cohesion, or transmits traditional values to subsequent generations. These traditions reflect norms of care and behaviour based on age, life stage, gender, and

social class. While many traditions promote social cohesion and Unity, others erode the physical and psychological health and integrity of individuals, particularly girls and women. Factors such as limited access to education, information, and services allow those that may be most harmful to persist. This research focuses on those cultural practices responsible for high infant mortality rate in Wammako Local government area of Sokoto State, for instance, Female genital cutting, shaving of infants hair with unsterilized blades, early marriage, preference for male children, tribal marking etc.

The Hausa society located in the Northern part of Nigeria, still have some reported cases of female genital cutting which results to different health implications such as V.V.F, excess blood letting and sometimes results to the death of the infant (UNFPA, 2007). Female genital cutting exposed females to so many diseases that can lead to death for instance a study in Maharashtra in India reveals that female genital cutting is associated with high level of infant mortality (Griffiths et. al, 2003).

In many African culture around the world, women do not decide on their own to seek medical care; the decision belongs to their male partner or to senior members of the family. This male dominated structure of the African family, places women in an inferior status creating a situation of inequality with respect to rights covering most facets of life (El safty,2001).

High rate of infant mortality is an indicator of societal problems and general discrepancies in people's health condition. If infant mortality is lowered, children will likely survive until maturity thereby contributing substantial years to life expectancy of the

population. In addition, high infant mortality means that parents cannot be sure their children will survive to contribute to the family economy and to take care of them in their old age. The parents are thus caught in a death trap, and they have to keep producing, because child birth in third world countries is often but by no means always a supportive one (Doyal, 2002:128).

Changing the cultural practices of the people requires an understanding of the practices, its meaning and reason for doing it and the knowledge of the people about its implication (Doyal, 2002, 10). In cases of cultural practices affecting infant mortality one can only understand the causes when a study is conducted

1.2 OBJECTIVE OF THE STUDY

This study is aimed at showing the relationship between cultural practices and infant mortality in Wammako Local Government Area of Sokoto State Nigeria. The specific objectives of the study are the following.

- (1) To assess people's awareness of the negative impact of these cultural practices and to determine the demographic characteristics of respondents; sex, age, and level of education.
- (2) To examine the relationship between restricted maternal right and infant mortality.
- (3) To examine the relationship between traditional circumcisions carried out by traditional experts and infant mortality.
- (4) To show if mother's participation in decision making affect the level of infant mortality.

1.7 SCOPE OF THE STUDY

The scope of this study covers only Wammako Town, In Wammako Local Government area of Sokoto State. This study limits itself to those cultural practices and attitudes that are associated with child health, maternal rights and are directly or indirectly linked to infant mortality. The study focuses on reproductive mothers, but also targets groups like medical practitioners and traditional birth attendants.

1.8 JUSTIFICATION OF THE STUDY

By the word justification, it ask about why a researcher should conduct a specific study on a given area. The identification of the cultural practices that leads to infant mortality will reduce the high rate of infant mortality in Wammako.

There is a wide range of health conditions affecting infants in developing countries long term consequences. The focus on infant health, hinges on the fact that infant mortality is prevalent in developing nations.

The reason for conducting this research can be seen as follows;

- (1) The problem of infant mortality is a worldwide phenomenon but more Prevalent in developing countries like Nigeria, whose infant mortality rate is presently 79 deaths per 1,000 live births (World Population Data Sheet, 2014) infants constitute an important segment of any population; therefore low infant mortality contributes substantially to high life expectancy in the population. Thus, the study that would help to abolish the problem of infant mortality is justifiable.

- (2) The study of infant mortality is very important because it reveals how well the most vulnerable members of the population are treated. In addition, it will help alert the general populace about negative cultural practices and their implications for infant survival.
- (3) The study will help alert policy makers that decline in mortality will lead to greater survival of children and it will motivate people to think of limiting the number of children they would have. These can be achieved as the paper will serve as a form of awareness to both the policy makers and the people. The paper will in one way or the other motivate people to think of limiting the number of children they would have, because it brings out the dangers in infant health when not properly taking care of.

1.9 HYPOTHESES FORMULATION

- (1) The higher the mother's participation in decision making and the lower the level of infant mortality.
- (2) The higher the level of traditional circumcisions carried out by traditional experts and the higher the level of infant mortality.

1.10 OPERATIONALIZATION OF TERMS.

Culture: -That complex whole which includes knowledge, belief, and morals,law, custom, and any other capabilities and habits acquired by man as member of society (Tylor 1871:1). For the purpose of this research culture is defined in terms of those traditionally acquired knowledge and practices (in relation to women, child birth, and infant health) that have negative effects and could lead to infant mortality.

Cultural Practices: are those traditional practices that have been handed down from generation to generation (Spradley, 2000). For the purpose of this research, cultural practice is operationally defined as the collective practices and beliefs in relation to women's life, obstetric care and infant health which communities husbands, mothers etc. put into practice.

Infant Mortality: is death during the first years of life.

Maternal Right: The right of women to participate in decision making, which affects their infants, without any cultural restrictions.

Traditional Birth Attendants (TBAS): They are post menopausal, thought to have accumulated enough experience especially in obstetric and infant health. i.e. the care of women during and after pregnancy, and issues relating to infant health.

CHATER TWO

LITERATURE REVIEW AND THEORETICAL FRAME WORK

2.0 INTRODUCTION

Studies have been reported in different part of the world and in some parts of Nigeria regarding cultural practices and infant mortality. However, literatures related to the study are hereby presented under the following.

- (1) Causes of infant mortality.
- (2) Infant and maternal mortality trend in develop and developing countries.
- (3) Global rate of infant mortality: A Brief Review
- (4) Theoretical framework

2.1 CAUSES OF INFANT MORTALITY

In a study of the causes of infant mortality in Kebbi state Nigeria, Shehu (1999) explained that there are three major causes of infant mortality in Northern Nigeria which include female genital cutting, preference for sons runs deep, and neonatal tetanus. A similar analysis by Weeks (2005) explains that, one of the most important causes of death among infants is dehydration, which can be caused by almost any disease or dietary in-balance. Several other studies identified the common causes of child mortality to include, malaria, whooping cough, diarrhoea, tuberculosis and measles.

The UNFPA (2004) report has shown that in Nigeria, public and private health care services are limited especially for women in the rural areas, access to health personnel is also a problem because government in Nigeria have not provided a nation-wide access to health

delivery facilities, which is why USAID (2006) in its analysis highlighted that delivery and use of child survival and reproductive health services in Nigeria are very poor nationwide, while service delivery is poor nationwide, it is weakest in the north. Such a situation could lead to a higher rate of infant mortality in the north.

The influence of culture on the health of infants cannot be neglected in Nigeria, study of Kebbi state women conducted by Shehu (1999) showed that cultural restrictions imposed by male house-hold heads tend to hinder women's rights, because women (especially in the rural areas) cannot decide to seek healthcare for themselves or their babies in the absence of the husband or other male relatives. Such cultural practice is prevalent in some other parts of the world, and has an influence on infant mortality. On the other hand, the NCPEA (1995) reported that in many parts of southern Nigeria there has been an upsurge of many religious sects with followers who are made to believe that it is better to give birth and seek for help in the Church clinics than the hospital, such a practice can lead to the death of infants during complications.

2.2 INFANT AND MATERNAL MORTALITY TREND IN DEVELOPED AND DEVELOPING COUNTRIES

The 2006 census estimated that there are about 65 million females in Nigeria out of which 30 million are of reproductive age (15-49 years) Each year about 6 million women become pregnant, 5 million of these pregnancies result in child birth (WHO, UNICEF, UNFPA, 2007). Available data indicate that 59,000 women die yearly as a result of complications in child birth (WHO, 2007). A Nigeria woman is 500 times more likely to die

in child birth than European counterpart. Thus for all human development indicator, maternal mortality ratios show the greatest disparity between developed and developing countries. These deaths are largely preventable. Equally of concern is that yearly, about 1,080,000-1,620,000 Nigerian women and girls will suffer disabilities caused by complication during pregnancy and childbirth (HILL, world law, 2001).

For every one that dies 20-30 more suffer long term and short term disabilities such as chronic anaemia, maternal exhaustion or physical weakness, vesico-vaginal or Recto Vaginal fistula, stress incontinence chronic pelvic pain, PID infertility, Ectopic pregnancy and Emotional Depression. The UNFPA estimated that 2 million women suffer vesico vaginal fistula globally, 40 percent of these (800,000) women are in Nigeria, majority due to prolonged obstructed labour that often terminate in still birth or neonatal death (UNFPA, 2003). Child survival is equally affected too as the chances of survival of a child in the absence of his or her mother is greatly reduced in Nigeria, 340,000 infant die annually during delivery and shortly after delivery especially if the mother dies in child birth. These deaths are not unconnected with the poor maternal death services in the country and could be avoided through provision of quality and effective maternal and child health service.

2.3 GLOBAL RATE OF INFANT MORTALITY: A Brief Review

In the 1990s, it was reported that among the 56 developing countries surveyed for every 1,000 children born, an average of 68 die by age of one (population report, 2008). During the second half of the twentieth century, the less developed countries of the world were said to have experienced decline in infant mortality rate. Average infant mortality rate

fell from 2890 to 1010 of live birth (Wermuth 2003, 76) despite this assertion, the infant mortality rate for less level of countries was about ten times large as it was for more developed countries (Wikipedia, 2007) gaps in infant mortality are not necessary closing. The percentage decrease in Africa was not as great as for the other regions (Yankey and Anderton, 2001:155)

TABLE 2.3 : GLOBAL TERND IN INFANT MORTALITY (DEATH PER 1000 LIVE BIRTH).

S/NO	DEVELOPED COUNTRIES	2012	2013	2014
1	JAPAN	2	1.8	1.6
2	FRANCE	4	3.7	3.4
3	IYALY	3	3	3
4	UNITED STATES	6	5.5	5.3
5	DENMARK	3	3	3
6	SPAIN	4	3.3	3.6
7	HUNGARY	6	5	5
8	GERMANY	3	3	3
9	NEW ZEALAND	5	5	5
10	CANADA	5	5	5
11	UNITED KINGDOM	4	4	4

LESS DEVELOPED COUNTRIES

S/NO	LESS DEVELOPED COUNRIES	2012	2013	2014
1	SYRIA	13	12	12
2	SOUTH AFRICA	35	34	33
3	ZAMBIA	59	57	56
4	NIGER	79	77	74
5	BENIN	62	60	56
6	ZIMBABWE	58	55	55
7	ERITREA	38	37	36
8	NAMIBIA	36	36	35
9	KENYA	50	49	48
10	AFGANISTAN	74	72	70
11	NIGERIA	79	77	74

Source: - World Health Organization Estimates, 2014

Illustrations from Table 1: indicates the global trend in infant mortality from the table it can be seen that infant mortality is low and declining in developed countries compared to the figures in less developed countries where the percentage decrease is very low and the percentage increase is very high.

2.4 THEORITICAL FRAME WORK

Several theories like the sick role and the three phase delay model attempted to explain the issue of infant mortality (The theories will be reviewed) for the purpose of this research the three phase delay model will best explain the problems of infant mortality in Wammako Local Government.

The Sick Role Model

In the social system (1951) Talcott parsons put forward one of the most famous concepts in the sociology of health and illness. Instead of accepting the idea of sickness as a biological concepts, parsons suggested that it was a social concept, so being ill meant acting in different deviant ways compared to the norms. Being sick was therefore a form of social role, with people acting in a particular ways according to the culture of society. In modern western societies this involved four elements, two of which are right and two of which are obligations.

The Right of the Sick Role

- (1) The sick person has the right to be exempted from normal social obligations such as attending employment, or fully engaging in family activities, this can include

pregnant mothers having most of the family responsible taken away from her because of her condition.

However, the extent to which the person can take the sick role and so avoid normal duties depends upon the seriousness of the illness and the other people's acceptance that they are genuinely ill. For example, other family members in the case of an extended family might reject a pregnant mother's claim to be sick and unable to work, they may argue that the person is merely feigning illness. In case like this, a medical expert is called upon to decide on the validity of the claim to be sick.

- (2) The sick role is something that the person can do nothing about and for which they should not be blamed. They therefore have the right to be looked after by others. The sick role affectively absolves the person any blame for social deviance.

Obligations of the Sick Role

As well as there are two rights, there are also two related obligations.

- (1) The sick person must accept that the situation they are in is undesirable and that they should seek to get well as soon as possible.
- (2) The sick person must seek professional help and cooperate with the medical profession to get well.

According to Parsons, the rights of the sick role are completely dependent on the sick person undertaking these obligations, if not, their illness is not regarded as legitimate and they are seen unfairly appropriating the sick role.

The sick role has been criticized for only focusing on acute illness; it is not a useful concept when looking at chronic illness, where people are unwell for a long time with no apparent prospect of improvement and the obligations to get better as soon as possible is simply not applicable (Parsons, 1975). Responded to this critics by saying that although complete recover is not possible people can manage their illness, carrying on as normal life as possible.

Three Phase Delay Model

The three phase delay model was developed as a result of a multi-disciplinary study in the causes of maternal mortality in West African. This model can be used to explain the causes of infant mortality in Nigeria, for instance delay in seeking and receiving adequate care is the major cause of maternal death (Thaddeaus and Mane, 1990), which could also lead to the death of the infant. The delays may result from the mother's economic low status or low educational awareness status. It may also result due to mother's negative attitude toward modern health care system. In another dimension the mother's access to medical services, the quality of the medical services itself may also lad to delay. According to this model, delay is in three phase namely; phase 1, 2 and 3 delays.

In phase 1 delay: mother may delay seeking and receiving care due to social, beliefs and attitudes. Her status in the society, level of her economic status and her perception and quality of service. All these factors can influence the rate of infant mortality.

In phase two delay: There may be a delay due to the location and actual accessibility to health facility, resulting in infant mortality. For instance after the mother has decided to seek care (phase 1) it is the phase 2 that determined the time taken to reach the facility.

In phase 3 delay: This delay happens at the health care facility. It can be due the insufficient number of medical and nursing personnel at the facility or lack of equipment and supplies or the long bureaucratic process of admitting and treating a patient. Just as the above mentioned factors are seen as major causes of infant mortality because most cases of maternal mortality are associated with infant mortality.

This model is appropriate and ideal for this work because infant mortality in Wammako specifically result from the mother's economic status, her knowledge and attitudes with regards to health system or her access to services and quality of medical care infant deaths are always related to the mother's inability to handle health related issues.

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CHAPTER THREE

METHODOLOGY

4.0 INTRODUCTION

This chapter includes a brief introduction, history of the study areas, research design, study population, sample size and procedure, method of data collection, and methods of data analysis.

3.1 HISTORY OF STUDY AREA

Wamakko is a local Government area (L.G.A) is one of the 23 LGAs of Sokoto State established in 1989. It has its headquarters in Wamakko town (study area). The LGA is located in the western part of Sokoto. Bounded by Kware local government by the north, Bodinga local government by the south, Sokoto north local government by the east and Binji by the west (Information Officer Wamakko Local Government, 2015).

Wamakko local government has an area of 697km². The population of Wamakko is at 179, 619 (NPC, 2006). The concentration of wealth, prestige, the political, power and religious learning centres in Wamakko attracted large number of rural urban migrants, both from the neighbouring state and from distance regions. Presently Sokoto State University, National Youth Service Corps Camp (NYSC) Amusement Park etc. form some part of tourist centres in Wamakko (Wikipedia, 2013).

As of 2010, the research conducted by National Bureau of statistics, shows that the estimated rural-urban migrants in the area is about 4,536 and its increasing at the rate of 10% annually (NBS, 2010).

Wamakko settlement, the study site has semi urban feature, the town consist of 11 wards, and these wards includes; Arkilla, Bado/Kasarawa, Gumbi, Kalambainal/Girabshi, Gidan Buba/Gidan Yaro, Gidan Hamidu/Gidan Kaya, Wamakko, Dundaye/Gunburawa and Gwamatse. The inhabitants are mainly Hausa/Fulani and their main occupations include farmers and animal rearers. The study area is selected because it is a community that still retained it cultural values (Information Officer Wamakko Local Government, 2015).

3.6 RESEARCH DESIGN

The research is on cultural practices and infant mortality in Wamakko Local Government area of Sokoto state. This will employ explanatory design to explain the relationship between cultural practise and infant mortality.

The research will employ the quantitative method of data collection in which data will be gathered from survey (use of questionnaire). The questionnaires will be administered to 100 women of reproductive age (15-49). The questionnaire will involve both close and open ended questions.

3.7 STUDY POPULATION

A research population is all the existing members or elements of the group to whom the result of the investigation could be generalized into. Therefore the target population for the study was made up of married women (mother's) aged 15-49 years (female reproductive age) who must have given birth at least once in their life time. The population of Wammako was estimated to be 179,619 constituting 51,200 female (N.P.C. 2006).

3.8 SAMPLE SIZE AND PROCEDURE

In this study, the sampling method that will be adopted is multi-stage cluster sampling method because there is no exclusive list of the population and also due to the largeness of the study area.

The areas where the study is going to be carried out are Arkilla, Wamakko town, Bado / Kassarawa, Gwamatse, Kalambaina / Girabshi and Dundaye / Gunburawa. The process of selection involves breaking the areas into 6 cluster each of these clusters can be called wards, these six wards were selected out of the 11 wards in Wamakko local government, because of their high population and because they are communities that still retain their cultural values.

In each of these wards, there are more than five streets, therefore one street will be selected from each of the wards using simple random sampling method. And five households will be selected from these street, proportionate selection will be adopted in selecting samples because the proportionate selection enable the allocation of samples based on the strength of the population. Simple percentage will be adopted to get the proportionate percentage of the population per ward. A total of 100 questionnaires will be used for the study, and the questionnaires will be distributed based on the strength of each population per ward. This means that the allocation of the samples will be on the number of the total population per ward, and the ward with the higher population will have higher samples compared to the ones with less population.

In dividing the sample based on the proportionate percentage of the population per ward, Arkilla will be offered (30) samples due to its high population concentration, followed by Wammako town with (20), Bado/Kassarawa (15), Gwamatse (15), Kalambaina/Girabshi (10) and Dundaye/Gunburawa with (10) samples.

3.9 METHOD OF DATA COLLECTION

In this research, both primary and secondary sources of data will be used. The primary data will be collected through survey (use of questionnaires). The questionnaire will be designed to elicit information concerning the subject matter, this technique will be adopted because the population of the study area include both literates and illiterates. The questionnaire schedule will be divided into four sections, the sections are as follows; section A will deal with background information, section B will deal with maternal right, section C will deal with mortality and section D will deal with assessment of awareness. The questionnaire will be mixture of both close and open ended questions.

The secondary data will be collected through content analysis, in which different books and journals related to the subject matter will be reviewed.

3.6 METHOD OF DATA ANALYSIS

This study is primarily co-relational, intended to investigate the likelihood of a relationship between cultural practices and infant mortality. But it is more interested in identifying associations rather than cause and effect.

Correlational studies collect quantitative data, which are subject to statistical test that calculate the strength of the link (the chi-square test can measure whether an association exist

between two variables). Data collected will be processed and analysed using statistical packages for social science research (SPSS). The SPSS is a software that is used in quantitative calculations like frequency and chi-square.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter deals with the presentation and analysis of data. 100 questionnaires were administered and returned and they have been analysed in this chapter using simple percentage and chi-square.

4.2 Data Presentation and Discussion

SECTION 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENT

TABLE 4.1: Age Distribution of Respondents

Age	Frequency	Percent
15-19	14	14.0
20-24	15	15.0
25-29	6	6.0
30-34	20	20.0
35-39	36	36.0
40-44	4	4.0
45 and above	5	5.0
Total	100	100.0

Table 4.1 above shows that 14.0% of the respondents are between 15-19 years, 15.0% are between 20-24years, also, 6.0% of the respondents are between the ages of 25-29 years, 20.0% are between the ages of 30-34, 36.0% are between the ages of 35-39, 4.0% are between the ages of 40-44, while 5.0% are from the age of 45 and above. This implies that most of the respondents are matured couple.

TABLE 4.2: Level of Mother's Education

Educational Attainment	Frequency	Percent
Primary	45	45.0
Secondary	38	38.0
Higher	9	9.0
No schooling	8	8.0
Total	100	100.0

Table 4.2 above shows that 45.0% of the respondents have Primary education, 38.0% of the respondents have Secondary Education, 9.0% have higher education (tertiary education which range from OND / HND, B.Sc etc) while 8.0% did not attend any school. The implication of this is that the respondents in this community are not well educated.

TABLE 4.3: Level of spouse Education

Educational Attainment	Frequency	Percent
Primary	28	28.0
Secondary	45	45.0
Higher	24	24.0
No schooling	3	3.0
Total	100	100.0

Table 4.3 above shows that 28.0% of the spouse to the respondents have Primary education, 45.0% have Secondary Education, 24.0% have higher education (tertiary education which range from OND / HND, B.Sc etc) while 3.0% did not attend any school. The implication of this is that the spouses are a little more educated than their wives.

TABLE 4.4: Type of Mother's Occupation

Occupation	Frequency	Percent
Farming	43	43.0
civil service	4	4.0
Trading	11	11.0
Non	42	42.0
Total	100	100.0

Table 4.4 above shows the 43.0% of the respondents are farmers, 4.0% are civil servants, 11.0% are traders, and 42.0% are artisans and full house wife. This implies that most of the respondents are into farming and full house wife.

Section B

Table 4.5: Mother's Participation in underlisted areas

Item	Frequency	Percent
Deciding your own health care		
Low	48	48.0
Medium	40	40.0
High	12	12.0
Deciding your infant's health care		
Low	12	12.0
Medium	60	60.0
High	28	28.0
Decision on daily household purchase		
Low	17	17.0
Medium	26	26.0
High	57	57.0

Decision on how to spend your earning		
Low	68	68.0
Medium	23	23.0
High	9	9.0

Table 4.5 above shows that when it comes to participating in decision making, 48% of the respondents have low level of decision making on their own health care, 40.0% are at medium level while 12.0% are high level decision maker in that aspect. 12.0% of the respondents are low level decision makers in cases of their infant health care, 60.0% are at medium level while 28.0% are high level decision maker in that aspect. 17.0% of the respondents are low level decision makers when it comes to house hold purchase, 26.0% are medium level while 57.0% are high level decision maker in that aspect. 68.0% of the respondents are low level decision makers when it comes to how to spend their earnings, 23.0% are medium level while 9.0% are high level decision maker in that aspect. This implies that in most decision making issues, the wife does not have much say except in the porches of house hold goods. Even in spending their income, they have no say.

TABLE 4.6: Level of spouse participation in under listed areas

	Frequency	Percent
Deciding your own health care		
Low	17	17.0
Medium	53	53.0
High	30	30.0
Deciding your infant's health care		

Low	15	15.0
Medium	55	55.0
High	30	30.0
Decision on daily household purchase		
Low	12	12.0
Medium	51	51.0
High	37	37.0
Decision on how to spend your earning		
Low	10	10.0
Medium	35	35.0
High	55	55.0

Table 4.6 above shows the level of a spouse participating in decision making, 17.0% of the respondents have low level of decision making on their own health care, 53.0% are at medium level while 30.0% are high level decision maker in that aspect. 15.0% of the respondents are low level decision makers in cases of their infant health care, 55.0% are at medium level while 30.0% are high level decision maker in that aspect. 12.0% of the respondents are low level decision makers when it comes to house hold purchase, 51.0% are medium level while 37.0% are high level decision maker in that aspect. 10.0% of the respondents are low level decision makers when it comes to how to spend their earnings, 35.0% are medium level while 55.0% are high level decision maker in that aspect. This implies that in all decision making issues, the spouse have much say. Even in spending their income, they have more say on their own and that of their wife.

TABLE 4.7: What to do if Husband is absent during birth and health problem

Decision	Frequency	Percent
Consult my in-law	47	47.0
wait for my husband	27	27.0
send for traditional healer	26	26.0
Total	100	100.0

Table 4.7 above shows that 47.0% of the respondents will consult their in-laws in time of child birth or other health challenge, 27.0% will wait for their husband, 26.0% will send for traditional healers.

TABLE 4.8: Whether a mother is exposed to restrictions

Permission	Frequency	Percent
Yes	90	90.0
No	10	10.0
Total	100	100.0

The table **4.8** above shows that 90.0% of the respondents said that they are exposed to restrictions while 10.0% said no they are not

TABLE 4.9: Type of Restrictions

Restriction	Frequency	Percent
from meeting friends	78	78.0
from going out	16	16.0
from relating with opposite sex	6	6.0
Total	100	100.0

Table 4.9 above shows that 78.0% of the respondents said that they are restricted from meeting friends, 16.0% said they are restricted from going out while 6.0% said that they are restricted from relating with the opposite sex.

TABLE 4.10: Who enforce these restrictions

Enforcer	Frequency	Percent
Husband	33	33.0
Culture	39	39.0
Religion	28	28.0
Total	100	100.0

Table 4.10 above shows that 33.0% of the respondents said that their husband is the enforcer of the restriction, 39.0% said that the culture is the enforcer of the restricting while 28.0% said that the religion is the enforcer of the restriction. This implies that cultural values are held in high regards in that community.

TABLE 4.11: Numbers of children ever born

Response	Frequency	Percent
1	14	14.0
2-3	23	23.0
4-5	38	38.0
6+	25	25.0
Total	100	100.0

Table 4.11 above shows that 14.0% of the respondents have only given birth to one child, 23.0% have between 2-3 children, and 38.0% have between 4-5, while 25.0% had from six children and above. This implies that the average family has between 4-5 children.

TABLE 4.12: Numbers of children alive

Responses	Frequency	Percent
1	7	7.0
2-3	44	44.0
4-5	20	20.0
6+	29	29.0
Total	100	100.0

Table 4.12 above shows that 7.0% of the respondents have only one child still alive, 44.0% have between 2-3 children, and 20.0% have between 4-5, while 29.0% had from six children and above still alive. This implies that there is a tendency that the families with one child must have lost their child likewise family with 4-5 children if the figure above is to be compared with the previous figure the loss stood at 21%.

Section D:

TABLE 4.13: Mother's view on cultural practice that can lead to infant mortality

Item	Frequency	Percent
Female genital cutting		
Yes	78	78.0
No	22	22.0
Abrupt weaning of child		
Yes	92	92.0
No	8	8.0
Neonatal; tetanus		
Yes	68	68.0
No	32	32.0
Abrupt immunization		
Yes	56	56.0
No	44	44.0
Local circumcision		

Yes	52	52.0
No	48	48.0
Applying of cow dung on the umbilical cord of the baby		
Yes	88	88.0
No	12	12.0
Local scarification		
Yes	100	100.0

Table 4.13 above shows how some cultural practices can lead to infant mortality. 78.0% of the respondents said yes female genital cutting can lead to infant mortality while 22.0% said no, it can't. 92.0% of the respondents said yes abrupt weaning of a child can lead to infant mortality while 8.0% said no, it can't. 68.0% of the respondents said yes neonatal tetanus can lead to infant mortality while 32.0% said no, it can't. 56.0% of the respondents said yes abrupt immunization can lead to infant mortality while 44.0% said no, it can't. 52.0% of the respondents said yes local circumcision can lead to infant mortality while 48.0% said no, it can't. 88.0% of the respondents said yes applying cow dung on the umbilical cord of the baby can lead to infant mortality while 12.0% said no, it can't. lastly, 100.0% of the respondents said yes local scarification can lead to infant mortality. This implies that all the cultural practices mentioned above can lead to infant mortality.

TABLE 4.14: Mother's view based these cultural practice

Response	Frequency	Percent
Good	7	7.0
Fair	90	90.0
Bad	3	3.0
Total	100	100.0

Table 4.14 above shows that 7.0% of the respondents said that cultural practices are good, 90.0% said they are fair while 3.0% said they are bad. It can be deduced from the fence

sitting response of the respondents that there is high tendency that this cultural practices is not fair if it is to be related with the previous question and their answers. Their sitting on the fence answers may be as a result of not wanting to tarnish their culture or cause troubles for themselves.

TABLE 4.15: Whether restricting maternal rights can lead to infant mortality.

Response	Frequency	Percent
Yes	68	68.0
No	32	32.0
Total	100	100.0

Table 4.15 above, shows that 68.0% of the respondents said that restrictions can lead to infant mortality while 32.0% said no, it cannot lead to that. This is because the consequences of every of the restriction at times of emergencies can be very futile.

TABLE 4.16: Whether the weight of infant contributes to his survival

Problems	Frequency	Percent
Yes	64	64.0
No	36	36.0
Total	100	100.0

Table 4.16 above shows that the 64.0% of the respondents said yes while 36.0% said no. this implies that child weigh during birth can contribute to their survival.

TABLE 4.17: Whether traditional circumcision can leads to infant mortality

Response	Frequency	Percent
Yes	64	64.0
No	36	36.0
Total	100	100.0

Table 4.17 above shows that 64.0% of the respondents said yes traditional circumcision can lead to infant mortality while 36.0% said no, it cannot.

4.3 STATISTICAL INFERENCE

HYPOTHESES

HO₁: There is no relationship between higher mother's participation in decision making and the lower level of infant mortality.

Item	Observed N	Expected N	Df	x-cal	Xcri	Sig	Decision
Low	12	33.3	2	35.840 ^a	5.991	0.05	Reject Ho`
medium	60	33.3					
High	28	33.3					

Table 1: shows that the calculated value (35.840^a) is more than the table value (5.991). Since the X^2 is greater than the X^2_t therefore we reject the Null hypothesis and accept the alternative hypothesis. The implication of this result is that there is relationship between higher mother's participation in decision making and the lower level of infant mortality.

HO₂: There is no relationship between the level of traditional circumcisions carried out by traditional experts and the higher level of infant mortality.

Table 2 : Chi-square

Item	Observed N	Expected N	Df	x-cal	Xcri	Sig	Decision
Yes	64	50.0	1	7.840 ^b	3.841	0.05	Reject Ho`
No	36	50.0					

Table 2: shows that the calculated value (7.840^b) is more than the table value (3.841). Since the X^2 is greater than the X^2_t therefore we reject the Null hypothesis and accept the alternative hypothesis. The implication of this result is that there is relationship between the

level of traditional circumcisions carried out by traditional experts and the higher level of infant mortality

4.4 DISCUSSION OF THE FINDINGS

This research showed that there are much restrictions on the maternal rights which have been placed by the culture and that there is low allowance for input in decision making with the family on both minor and vital issue which is not to acceptable for the growth of the family and the reduction of infant mortality. The research found out that there is increase in the mortality rate within families with 4-5 children, then those with a child and the percentage is 21%. In addition, there are some cultural practices that have affected the rate of child mortality and this include female genital cutting, abrupt immunization etc. In addition, though the people of the community are aware of the implications of some of these cultural values but fear of the aftermath has kept them from reacting.

Conclusively, the research showed that there is relationship between the levels of traditional circumcisions carried out by traditional experts and the higher level of infant mortality because of some procedures and instruments that are adopted by these so called traditional experts. Also, there is relationship between higher mother's participation in decision making and the lower level of infant mortality since the mother understand the infant very well, she can say what is required per time and go extra mile to put them in place.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 INTRODUCTION

This chapter gives a clear perspective on each of the following items; summary of the findings, conclusion, recommendations and it also makes suggestions for further research study.

5.2.1 SUMMARY

Chapter one discuss the introduction and background to this study, the statement to the problem, the justification of the study, the scope it would cover and the limitations as well as the cauterization were cleverly explored and the definition of terms.

The chapter two contained the literature review under the following sub headings

- (1) Causes of infant mortality.
- (2) Infant and maternal mortality trend in develop and developing countries.
- (3) Global rate of infant mortality: A Brief Review
- (4) Theoretical framework

The chapter three contains the method and it presents the introduction, the history of the study area, the research design gave a basic knowledge on the nature of the research with is Descriptive survey research, the study population, the sample for the study was one hundred respondents who were randomly selected and questionnaires were administered to them as instrument for the data collection. The returned questionnaires were mechanically coded and analyzed using simple percentage and chi- square.

The chapter four presentations the result of the findings in tabular form, the discussion of each table was placed under it to avoid complications, lastly the discussion of the findings was presented in the line with the hypothesis. Thus this research found out that there is relationship between the level of traditional circumcisions carried out by traditional experts and the higher the level of infant mortality and that there is relationship between higher mother's participation in decision making and the lower the level of infant mortality

Chapter five is the last chapter and it presents the summary of entire work. The chapter contains summary, findings, conclusion, and recommendations which are discussed under their respective subheadings below.

5.3 SUMMARY OF THE FINDINGS

1. There is relationship between the level of traditional circumcisions carried out by traditional experts and the higher level of infant mortality
2. There is relationship between higher mother's participation in decision making and the lower level of infant mortality
3. That women are weak decision makers when compared with the men
4. That there are certain restriction placed on the woman by culture
5. That there are some cultural practices that can enhance infant mortality

5.4 CONCLUSION

The research concludes that the cultural practice and infant mortality in Wamako Local Government Area of Sokoto is high and as such critical action must be taken to nip it in

the bud before it gets out of hand, even though the community dwellers are aware of this they tend not to react because of the fear of the consequence.

5.5 RECOMMENDATION

The recommendations are base on the findings and the conclusion drawn from the study, and from the critical assessment of the result in the chapter four. These include:

- (1) Proper awareness of the negative impact of some of these cultural practices on infant mortality should be created.
- (2) The restrictions of maternal right should be reviewed.
- (3) The female should be allowed more opportunity in decision making within the home.

5.6 SUGGESTION FOR FURTHER RESEARCH

It is suggested that the following under listed area can be considered for further research:

- Assessing the impact of infant mortality on the marital stability of people in Wamako LGA.

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APPENDIX: QUESTIONNAIRE

USMANU DANFODIYO UNIVERSITY, SOKOTO DEPARTMENT OF SOCIOLOGY

Dear respondents, I am a final year student with the Department of Sociology, Usmanu Danfodiyo University, Sokoto. Undertaking a research on the topic “**Cultural Practices and Infant Mortality in Wamakko Local Government in Sokoto State**”. I would like you to respond to the following questions, your responses and views will be treated with utmost confidentiality. Please you may tick one box below as appropriate.

Section A; Background Information

1. Age

- a. 15-19 []
- b. 20-24 []
- c. 25-29 []
- d. 30-34 []
- e. 35-39 []
- f. 40-44 []
- g. 45 and above []

2. What is the highest level of education you attained

- a. Primary []
- b. Secondary []
- c. Higher []
- d. No schooling []

3. What is the highest level of education your spouse attained?

- a. Primary []
- b. Secondary []
- c. Higher []
- d. No schooling []

4. Type of occupation
 - a. Farming []
 - b. Civil service []
 - c. Trading []
 - d. None []

Section B: Maternal Rights

5. How would you describe your level of participation in the following areas of decision making?

	Low	Medium	High
a. Deciding your own health care	[]	[]	[]
b. Deciding your infant's health care	[]	[]	[]
c. Decision on daily household purchase	[]	[]	[]
d. Decision on how to spend your earning	[]	[]	[]

6. How would you describe your spouse's level of participation in the following areas of decision making?

	Low	Medium	High
a. Deciding your own health care	[]	[]	[]
b. Deciding your infant's health care	[]	[]	[]
c. Decision on daily household purchase	[]	[]	[]
d. Decision on how to spend your earning	[]	[]	[]

7. If your husband is not at home in time of child birth and health related problems what would you do?
 - a. Consult my in-law []
 - b. Wait for my husband []
 - c. Send for traditional healer []
 - d. Take on emergency transportation to the nearest hospital.

8. Are you exposed to restrictions?
 - a. Yes []
 - b. No []

9. If yes, what are these restrictions?

10. Who enforce these restrictions?

- a. Husband []
- b. Culture []
- c. Religion []
- d. Others, specify []

Section C: Mortality

11. Number of children ever born?

- a. 1 []
- b. 2-3 []
- c. 4-5 []
- d. 6+ []

12. Number of children alive.

- a. 1 []
- b. 2-3 []
- c. 4-5 []
- d. 6+ []

13. For those not alive give the following information

S/N	Sex	Age at death	Cause(s) of death
1			
2			
3			
4			
5			
6			
7			

Section D: Assessment of Awareness on the Negative Effect of Cultural Practices that Leads to Infant Mortality

14. Do you think the following cultural practices can lead to infant mortality?
- | | Yes | No |
|---|-----|-----|
| a. Female genital cutting | [] | [] |
| b. Abrupt weaning of child | [] | [] |
| c. Neonatal; tetanus | [] | [] |
| d. Abrupt immunization | [] | [] |
| e. Local circumcision | [] | [] |
| f. Applying of cow dung on the umbilical cord of the baby | [] | [] |
| g. Local scarification | [] | [] |

15. How do you view these practices?

- a. Good []
- b. Fair []
- c. Bad []

16. Do you think restricting maternal right can lead to infant mortality?

- a. Yes []
- b. No []

17. If yes how? _____

18. Do you think the weight of an infant contributes to his survival?

- a. Yes []
- b. No []

19. Do you think traditional circumcisions can lead to infant mortality?

- a. Yes []
- b. No []

20. If yes how? _____
