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Cultural Malpractices During Pregnancy, Child Birth and Postnatal Period Among Women of Child Bearing Age in Limmu Genet Town, Southwest Ethiopia

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Abstract: Back ground: Everyday, at least 800 women die worldwide from the complications of pregnancy & child birth, 90% of which occurring in Asia & Sub Saharan Africa. These shows, maternal death in developing country is high. One of the contributing factors for these problems is cultural malpractices during pregnancy and child birth. The actual incidence of cultural malpractices in developing countries accounts at about 5-15% of maternal deaths. Objective: To assess prevalence and factors associated with cultural malpractice practiced during pregnancy, child birth and postnatal period among women of child bearing age in Limmu Genet town, Southwest Ethiopia. Methods: Community based cross sectional study was conducted to determine prevalence and factors associated with cultural malpractices that take place during pregnancy, child birth and postnatal period among women of the reproductive age group. The study was conducted from June to September 2014. Data was collected by using interviewer administered pretested questionnaire by trained high school students. The collected data was entered to Epidata 3.1 and transported to SPSS version 17 for data analysis. Data was presented by using tables and graphs. The association between variables was tested by using X^2 test with a p-value of less than 0.05 was used to declare the significance of the association. Result: Out of 303 women 58(19.1%) practiced nutritional taboo, 67(22%) women practiced abdominal massage and 116(38.3%) delivered their babies at home, 33(28.4%) washed their babies immediately after birth and 26(22.41%) did not give collostrum to new born. Educational status was significantly associated with nutritional taboo, abdominal massage, home delivery and avoiding colostrum feeding to new born. Conclusion: The prevalence of cultural malpractices during pregnancy, delivery and postpartum in the study area was high. Therefore health education and promoting formal female education are important to decrease or avoid these cultural malpractices.

Keywords: Cultural Malpractice, Pregnancy, Labour, Postpartum, Ethiopia

1. Introduction

Globally, over 300,000 maternal deaths occur each year. This figure translates in to more than 1400 child birth deaths every 24 hours. Nearly half of all maternal deaths occur in Africa. For every woman who dies, another 100 women survive childbearing but suffer from serious disease, disability, or physical damage caused by pregnancy related complications. Maternal morbidity in the form of uterine prolapse, pelvic inflammatory diseases, vesico vaginal fistula, urinary and fecal incontinence, infertility and pain during intercourse are few of the long term consequences of pregnancy related complication. A million or more children are left motherless each year when mother dies from pregnancy related causes. Thus the United Nations' millennium developmental goals (MDGs) set in 2000 targeted a 75% reduction in the maternal mortality ratio by 2015 (1,2). Every day at least 800 women are dying worldwide from the complication of pregnancy and child birth, of which majority occurring in Asia and Sub Saharan Africa. Maternal mortality rate shows the largest between developed and developing countries. In Ethiopia, maternal and infant mortality and morbidity level are the highest in the world. The maternal mortality ratio in the year 2005 was 673 per 100,000 live births and IMR 59 deaths per 1000 live births (1,3).

Many mothers suffer from infection of the reproductive tract and neonatal sepsis due to unclean environment and inappropriate care during pregnancy and delivery, which, infant improperly delivered by unskilled birth attendants, and/or the traditional practices performed during delivery are the major cause of sepsis and death. The actual incidence in developing country is not known, but it accounts 5-15% (3). Some of the determinant factor for this are the general socio –economic conditions, educational status, the believes of the community on modern health care service & enabling to use the available modern health care service, the socio cultural believes of the community and simply using cultural way of treating the mother during pregnancy, delivery and postpartum period. In the same way such cultural practices may be accompanied by numerous complications which result to permanent damage to the body and even death. On the other hand, pregnancy by itself has not been considered as a risk for maternal health in Africa during pregnancy (4). A life time risk for maternal death in developed countries is forty times higher than that of developed countries. Bleeding, obstructed labor, hypertensive disorder (pregnancy toxemia), unsafe abortion, sepsis and home delivery contribute for up to 80 % of maternal death with resultant increased fetal loss, prenatal mortality and poor survival of children (5). Cultural practices during pregnancy and child birth are the common practices in the developing countries. This cultural effect may be beneficial, neutral, or harmful. Despite the lack of precise information, harmful cultural practices have a serious effect on the health of pregnant women, commonly in developing country like Ethiopia. As in developing countries, in Ethiopia, the great majority of women deliver at home and follow the cultural birth customs. This create problems for several years that we couldn't overcome much of the risk which is associated with harmful cultural practices which are performed at each individual's home during delivery. Thus the benefits of modern maternity care have been influenced largely by the cultural practices under taken during pregnancy and child birth (6).

In Ethiopia, culturally, the pregnant women avoided milk, honey, meat and some valuable food stuffs in order to avoid large baby and difficulty of labor. Her abdomen is massaged to relieve back pain and to correct the position of the fetus mostly by untrained traditional birth attendants. In addition to this, different herbal medicines or drugs are taken during pregnancy and child birth in many regions as treatment for some pregnancy and pregnancy related symptoms. Also the pregnant women do extraneous working activity till the last trimester of pregnancy because they believe that it will help to make the labor easier and reduce the body weight of the infant (7). In Ethiopia, data on cultural practice during pregnancy and child birth is not completely understood (in complete) and little is known about either beneficial or full aspect both in local and national level. No study was conducted in Limmu Genet and around it to assess the problem. Thus this study will attempt and help to determine the type and magnitude of cultural malpractice performed during pregnancy, child birth and immediate post natal time among reproductive age group women of an area. As it is seen in other part of Ethiopia, in Limmu Genet and around there may be different cultural practices which is performed during pregnancy and /or child birth, but there is no data which clearly indicate the types & prevalence of cultural malpractice and their influencing factors and put base line for further research in order to recommend the necessary intervention to concerned body. In Ethiopia, different cultural practices have been under taken during pregnancy child birth in almost all the regions. But there is no study done here which clearly explain it. Therefore purpose of study was to assess the prevalence and factors associated with cultural malpractices during pregnancy, birth and postpartum in study area. It is hoped that the result of this study will provide program and policy makers with data on cultural malpractices.

2. Methods and Materials

2.1. Study Area and Period

The study was conducted in Limmu Genet town, Jimma zone, Oromia region, Southwest Ethiopia. The town has two kebeles and total population of 11,991. There were 1304 women of reproductive age. It is 75km from Jimma town and 435 km from Addis Ababa. The town has one district hospital, one health center and five private clinics. The study was conducted from June to September 2014.

2.2. Study Design

The study design was community based cross-sectional.

2.3. Source Population

Source population was all women of reproductive age group in Limmu Genet town who experienced at least one pregnancy.

2.4. Study Population

All randomly selected women of reproductive age (15-49) who experienced at least one pregnancy in Limmu Genet town.

2.5. Sample Size and Sampling Technique

Sample size was calculated by using single population proportion formula to calculate sample size.

$$n = \frac{z^2 pq}{d^2} = 384$$

$$nf = \frac{n \times N}{N \pm n} = \frac{384 \times 1304}{384 \pm 1304} = 296$$

nf = 296 +14.8 =312
n=required sample size
p=proportion=0.5
d=marginal error=0.05
z= standard score=1.96
N=finite population size (1304)

To select 312 women systematic random sampling was conducted by considering list of women with at least one pregnancy as sampling frame.

2.6. Data Collection

Data was collected using structured questionnaires prepared in English and translated to Afan Oromo (local language). The questionnaire was pretested before commencement of actual data collection. The questionnaire contains three parts: socio demographic characteristics, reproductive health part and practices of cultural malpractices. Data collection was conducted after obtaining permission from concerned officials. Five data collectors from high school students trained about the study and on data collection.

2.7. Data Quality Control

One week before actual survey pretest was carried out in 5% of study population and necessary modification was made before going to apply on the study subject. Data was collected carefully by the principal investigators and trained high school students to get the reliable and necessary in formation according to the aim of the study. The principal investigator had made an ongoing checking each day during the data collection to ensure the quality of data by checking filled questionnaires.

2.8. Data Analysis

The collected data was entered to Epidata 3.1 software and then transported to SPSS version 17 for data analysis. Frequencies were calculated to determine prevalences. Association between variables was tested by using x^2 test at 95% confidence level and a p-value of less than 0.05 was used to declare the significance of the association. Finally tables were used to present the findings.

2.9. Ethical Consideration

Ethical clearance and formal letter were obtained from Jimma University. Letter was also obtained from the administrative counsel of Limmu Genet administration. Confidentiality of the respondents was assured that any person's name was not appeared on research documents and respondents was informed about the aim of the study.

3. Results

3.1. Socio Demographic Characteristics

Regarding to the socio demographic characteristics of the respondents, 107(35.3%) were in the age group of 25- 29. Majority of them were Muslim 119(39.3%) and Oromo 177(58.4%) by religion and ethinicity respectively. Out of 303, 265(87.5%) were married and 157(51.8%) completed grade 1- 8. Concerning occupation 187(58.7%) were house wives (Table 1).

3.2. Cultural Malpractices During Pregnancy

This study assessed the respondents' experiences of malpractices during pregnancy. Out of 303 women 58 (19.1%) practiced nutritional taboo, 67(22%) women practiced abdominal massage and 116 (38.3%) delivered their babies at home (Table 2).

Table 1. *Socio demographic characteristics of respondents in Limmu Genet town, 2014.*

Characteristics		Number	Percent
Age	15-19	4	1.3
	20-24	92	31
	25-29	105	35.3
	30-34	48	16.2
	35-39	51	16.8
	40-44	8	2.4
Religion	Muslim	119	39.3
	Orthodox	112	37
	Protestant	49	16.2
	Others	23	7.5
Ethnicity	Oromo	177	58.4
	Amhara	63	20.8
	Gurage	35	11.6
	Others	23	8.2
Educational status	Illiterate	111	36.6
	G 1-8	157	51.8
	G 9-12	21	6.9
	12+	14	4.7
Marital status	Single	9	2.8
	Married	265	87.5
	Divorced	14	4.6
	Widowed	15	4.9
Occupational status	House wife	187	58.7
	Student	12	4
	Employer	39	12.9
	Farmer	46	15.2
	Merchant	28	9.2

Table 2. *Prevalence of cultural malpractices during pregnancy and child birth among women of Limmu town, 2014.*

Cultural malpractices during pregnancy	Responses			
	Yes		No	
	Number	%	Number	%
Food taboos	58	19.1	245	88.9
Abdominal massage	67	22	236	78
Home delivery	116	38.3	187	61.7
Cutting cord by unclean blade (N=116)	5	4.31	111	95.69
Avoiding collestrum(N=116)	26	22.41	90	77.58
Washing baby immediately after delivery(N=116)	33	28.44	83	71.55

3.3. Cultural Malpractices During Delivery and Post Natal Period

From 116 women who gave birth at home 33(28.44%) washed their babies immediately after birth. About 26(22.41%) did not give collustrum to new born and 5(4.31%) cut umbilical cord by unsterile material (Table 2).

3.4. Factors Associated with Cultural Malpractics

Nutritional taboo was cross tabulated against sociodemographic characteristics. The x^2 test was conducted to assess if there was significant association between them. There was significant association between age and educational status of respondents and nutritional taboo (Table 3). Age group and educational status were significantly associated with home delivery and abdominal massage (Table 4 and 5). Age group, educational status and ethnicity were significantly associated with prohibiting colostrum(Table 6).

Table 3. *Association of nutritional taboo with age group, religion, Educational status and ethnicity among Limmu genet women, 2014.*

Characters		Nutritional taboos		Total	P value
		Yes	No		
Age	15-19	0	4	4	<0.05
	20-24	6	86	92	
	25-29	21	84	105	
	30-34	19	29	48	
	35-39	10	41	51	
	40-44	2	6	8	
	Total	58	245	303	
Religion	Muslim	29	90	119	>0.05
	Orthodox	17	75	112	
	Protestant	5	44	49	
	Others	3	20	23	
	Total	58			
Educatiuonal status	Illiterate	49	62	111	<0.05
	Primary school	9	148	157	
Ethinicity	Oromo	27	150	177	>0.05
	Amhara	21	42	63	
	Gurage	4	31	35	
	Others	6	21	23	

Table 4. *Association of Abdominal Massage with age group, religion, Educational status and ethnicity among Limmu Genet women June 2013 G.C.*

Characters		Abdominal massage		total	P value
		Yes	No		
Age	15-19	0	4	4	<0.05
	20-24	3	89	92	
	25-29	14	91	105	
	30-34	16	32	48	
	35-39	27	24	51	
	40-44	7	1	8	
Religion	Muslim	26	93	119	>0.05
	Orthodox	24	88	112	
	Protestant	12	37	49	
	Others	5	18	23	
Educational status	Illiterate	51	60	111	<0.05
	1-8	16	141	157	
Ethnicity	Oromo	25	152	177	>0.05
	Amhara	21	42	63	
	Gurage	14	21	35	
	Others	9	18	23	

Table 5. *Association of home delivery with age group, religion, educational status and ethnicity among Limmu Genet women, 2014.*

№	Characters		Home delivery		total	P value
			Yes	No		
1	Age	15-19	0	4	4	<0.05
		20-24	6	86	92	
		25-29	46	59	105	
		30-34	23	25	48	
		35-39	35	16	51	
		40-44	6	2	8	
2	Religion	Muslim	45	74	119	>0.05
		Orthodox	42	70	112	
		Protestant	18	31	49	
		Others	11	12	23	
3	Educational	Illiterate	83	28	111	<0.05
		1-8	33	124	157	
4	Ethnicity	Oromo	68	109	177	>0.05
		Amhara	29	34	63	
		Gurage	9	26	35	
		Others	5	22	23	

Table 6. *Association of avoiding collestrum from new born with age group, religion, educational status and ethnicity among Limmu Genet women, 2014.*

Characters		Giving collestrum for new born		Total	P value
		Yes	no		
Age	15-19	4	0	4	<0.05
	20-24	90	2	92	
	25-29	101	4	105	
	30-34	35	13	48	
	34-39	47	4	51	
	40-44	5	3	8	
Religion	Muslim	107	12	119	>0.05
	Orthodox	105	7	112	
	Protestant	45	4	49	
	Others	20	3	23	
Educational status	Illiterate	93	18	111	<0.05
	1-8	149	8	157	
Ethnicity	Oromo	166	11	177	<0.05
	Amhara	54	9	63	
	Gurage	31	4	35	
	Others	25	2	23	

4. Discussion

This community based study has attempted to assess the prevalence and associated factors of cultural malpractices during pregnancy, delivery and postnatal period in Limmu Genet town, Jimma Zone, Southwest Ethiopia.

The result of the study revealed that the prevalence of nutritional taboo was 19.1%. This was lower than the study conducted in Shashemene which was 49.8% (8). But even if it seems lower, nutritional taboos have rampant effect on the outcome pregnancy. In our study nutritional taboo was significantly associated with educational status of mothers. This goes in line with the study conducted in Shashemene (8). This indicates that education has impact on avoiding nutritional taboos during pregnancy and hence avoid iits

consequences.

Our study indicated that the prevalence of home delivery was 38.3%. This was lower than the study conducted in Arbaminch zuria in south Ethiopia (9). In our study educational status of mothers was significantly associated with home delivey. This result was similar with the study conducted in Arbaminch, South Ethiopia.

This study revealed that the prevalence of abdominal massage during pregnancy was 22%. This was higher than the study conducted in Nigeria which was 14.79% (10). This indicates that our study participants were practicing abdominal massage apparently. This may cause adverse outcomes during pregnancy.

In the study conducted in Bangeladesh the prevalence of not giving colostrum was 41% (11). This was higher than the result of our study which was 22.41%. But our study result was higher than the study conducted in North Ethiopia on complementary feeding which was 10.75% (12).

In this study 28.4% washed their babies immediately after birth. This may cause negative effect on the new born. About 4.3% of respondents used unsterile material to cut the umblical cord during home delivery.

Overall this study showed that educational status was significantly associated with nutritional taboo, abdominal massage, home delivery and avoiding colostrum feeding to new born. This indicates that empowerment of women interms of education has unreplacable role in preventing cultural malpractices during pregnancy, delivery and postpartum. This is because poor knowledge is associated with cultural malpractices (13).

5. Conclusion

The prevalence of cultural malpractices during pregnancy, delivery and postpartum in the study area was high. Educational status was significantly associated with nutritional taboo, abdominal massage, home delivery and avoiding colotrum feeding to new born. Therefore health education and promoting formal female education are important to decrease or avoid these cultural malpractices.

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