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Research Article

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Traditional Birth Practices and Reasons for Preference of Home Delivery Among Women in Some Rural Communities of Plateau State

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Abstract

Introduction

It is difficult to imagine if Nigeria can meet up with the SDG target of global reduction of maternal mortality to 70/100,000 or the supplementary national target that no country should have an MMR greater than 140/100,000 considering the persistent high rate of home delivery. Women do not want to die during child birth, but various factors have kept them from delivering in the health

facilities. This research therefore set out to assess the birth practices and the reasons for home delivery among women in Jos South LGA, Plateau state.

Methodology

It was a community-based cross-sectional study conducted among 253 women who have ever given birth. A household survey was conducted to interview women who gave consent using an adapted questionnaire. The findings were analysed with Epi info version 3.5.4 statistical software.

Results

While 9.9% had tertiary education, 39.5% had no formal education. About 48% said they were forbidden from taking certain food items such as meat and some vegetables during pregnancy for reasons that the babies will either be too big or abnormal. Home delivery was 74% while delivery by skilled attendant was 31%. Almost all the home deliveries were attended to by traditional birth attendants, mothers-in-law and relatives. Reasons for home delivery were: lack of money for hospital bills, distance to health facilities, harsh treatment from health workers and interestingly is the birth position which 57.4% prefer squatting or sitting against the lithotomy position in the health facilities.

Conclusion

The study revealed high rate of home delivery and pertinent factors that influence home delivery, one of which is the birth positions they are compelled to take in the health facilities against their desired positions.

Introduction

Nigeria records one of the highest maternal mortality rate in the world with rate as high as 560 per 100,000 live birth and as high as 145 maternal deaths daily [1]. This high maternal mortality rate has been attributed to many reasons including lack of access to functional health care system, poverty, culture and some social factors spanning from the period of pregnancy to about 42 days after termination of the pregnancy [2].

Pregnancy and child birth is considered a significant event for most African women and so heralded by practices embedded in the customs believed to enhance the wellbeing of both the mother and the baby [3]. This is not different among Nigerian women whose culturally based beliefs about pregnancy and child birth determines the acceptable food, daily activities and even access to health care [3] Though some of the practices may be beneficial, some significant others are detrimental to the outcome of the pregnancy, depriving them of essential nutrients which results in malnutrition and other health related conditions that contributes to maternal mortality.

It is difficult to imagine that Nigeria can meet up with the SDG target of global reduction of maternal mortality to 70/100,000 or the supplementary national target that no country should have an MMR greater than 140/100,000 by the year 2030, considering the persistent high rate of home delivery attended to by

non-skilled personnel [4]. Women do not want to die during child birth, but the choice of home delivery which is still high in Nigeria is motivated by many factors such as economic, social, physical, cultural and institutional [5].

In delivering at home, women are mostly assisted by unqualified attendants who could be traditional birth attendants (TBAs), family members or neighbors. Although TBAs are known for their roles in assisting child deliveries especially in the rural settings and countries such as Ghana have recognized them in their health system, engaging them is questionable noting that they are not trained in dealing with complications which results in maternal death [6,7].

The high rate of home delivery and unacceptable maternal mortality rate in Plateau state and Nigeria despite effort and strategies put in place by the government to ensure skilled attendance at delivery, necessitated this study which is aimed at finding out some of the practices during pregnancy and delivery and the reasons for home delivery beyond the documented reasons.

Methodology

It was a community-based cross-sectional study conducted among 253 women who have ever given birth in Vom Community of Jos South LGA, Plateau State. Vom Community was purposively selected following a non-published history of high rate of home delivery despite the presence of a secondary health facility and several primary health care facilities in the community.

The sample size was calculated using the formula z^2pq/d^2 where p was the prevalence of home delivery which was 40% obtained from a previous study in Jos North LGA of Plateau State [8]. Consideration was given to the fact that the population was less than 10,000 so the sample size was further calculated thus: nf = n/1 + (n/N). Where, nf = minimum sample size for population <10,000; n = minimum sample size for population >10,000 initially calculated; and N = estimated total population of pregnant women in Jos South LGA, which was approximately 600. Therefore, n f = 368/ [1 + (368/600)] = 234 and the sample size was estimated to be 257 after factoring in 10% non- response rate.

The study population comprised of women of child bearing age who have delivered and reside in the community. The houses were enumerated and houses with women in this category were identified for the household survey. A systematic sampling technique was used to select the participants using a sampling interval of 3 derived by dividing the number of women in that age group who have delivered by the estimated sample size calculated.

After obtaining consent from the eligible women, data was collected using a semi structured interviewer administered questionnaire. The data was then analysed using with Epi info version 3.5.4 statistical software.

Results

A total of 235 women responded to the questionnaire. Most were married (95.7%) and 74.8% were in monogamous unions. Almost 40% of the women had no formal education and majority (91.7%) of the respondents were Berom by tribe, which is the indigenous tribe of the study area.

Food Recommended During Pregnancy

Most of the women (84.6%) reported having traditional food and medication recommended during pregnancy of which 38.3% used herbs, 27.9% special vegetables and 19.2% some form of proteins and 1.4% carbohydrate diet.

Forbidden Food During Pregnancy

Almost half (47.8%) of the women said they are forbidden from eating certain foods during pregnancy, 52.1% were forbidden from eating meat, 8.2% said some fruits and vegetables, 26.4% mentioned being forbidden from consuming certain herbs and 13.2% had restrictions on eating sugary food.

Reasons for Restriction of Some Food During Pregnancy

The reasons given for the restriction included: to avoid having big babies (73.3%), to avoid giving birth to abnormal babies (21%) to avoid preterm labour (1.7%) and 5% said to avoid having stillbirth babies.

Birth Practices

A history of the last delivery revealed that 74.2% delivered at home, while 25.8% delivered in the health facility. Delivery by skilled attendant was 31.1%, while 68.9% was by unskilled attendants; 39.5% were delivered by a traditional birth attendant (TBA) and 30.4% was by relatives which included mother in laws and aunts.

Reasons for Home Delivery

The reasons varied, 52.2% of the women said they received special practices during delivery such as massaging, head gripping, insertion of herbs into the vagina and sitz baths. Other reasons were; they did not like the birth position in the hospital (6.4%), lack of money to pay for hospital delivery (58.8%), harsh treatment from health care providers (26.8%) and 8% gave the lack of transport money to go to the hospital as reason.

When asked the preferred birth position, 45.1% said they preferred squatting, 42.7% said lying on their backs and 12.3% said sitting down.

Post-Partum Practices

45.8% said they are made to have hot baths after delivery, 21.3% said they are made to rest and 26.9% said they are given fluid diet during that period.

Discussion

Food Restriction/Taboos During Pregnancy and the Role of Nutrition in Pregnancy

Beliefs and traditions direct the kind of food consumed during pregnancy, while some may be beneficial, others may be harmful. The concern is that some of the recommended foods may be rich in a class of

nutrients but deficient in others or even harmful. The herbs that were mentioned as recommended by these women is feared to be harmful as the constituents of those herbs are not known. Fruits mentioned by a few may be beneficial. The danger of consuming herbs which could be potentially dangerous in pregnancy was also expressed in a study in Mexico [9].

Food taboos, restriction or recommended foods for pregnant women is a known practice across many nations especially in Africa [10]. This was our observations in this study which is also similar to findings from a study conducted in eastern Nigeria where some women did not eat nutritionally recommended foods such as meat, some fruits and vegetables because it was forbidden, believing it will cause either big babies or birth of abnormal babies [11,12]. The misconception towards certain foods deprives the mother and the foetus from essential nutrients placing the mother at risk of pregnancy complications such as anaemia in pregnancy, and maternal death [13-15]. Some women in Ethiopia also mentioned in a study that it is forbidden for them to consume vegetables as documented in this study [16].

Birth Practices and Reasons for Home Delivery

Nigeria has always recorded high prevalence of home delivery. A study conducted in Plateau state confirmed this finding [8, 17] The major concern about home delivery is the fact that rarely is it conducted by a skilled attendant as is the case in this study and other studies where majority of the home deliveries were conducted by TBAs and family relations [18]. Delivery by TBAs and unskilled attendants have been associated with high maternal mortality which is not unconnected with their poor knowledge on handling complications, the unhygienic environment and harmful practices such as introduction of some herbs into the vagina while conducting deliveries [18]. One wonders why despite the complications arising during home delivery, women still prefer to deliver at home. This study community is privileged to have both primary and secondary health facilities situated there but despite this, there is still a high rate of home delivery. Some of the reasons given by the women for their choice of home delivery aside the common complaint of lack of money for hospital bills and the harsh treatment by health care providers is the birth position they are forced to take in the health facilities. More than half of the women did not like the conventional lithotomy position which they are subjected to in the health facilities. Our question is; should this be the only birth position in the health facility? Is this birth position convenient for the health provider or the woman? Some have opined that this birth position is really for the convenience of the health provider and not for the women [19].

The birth position of sitting and squatting as preferred by most of the women here has been reported to have some benefit. The sitting position is said to combine the force of gravity and relaxation which helps to ease delivery while the squatting position helps in opening the pelvis and assisting the baby's passage [20]. This could be some of the silent issues responsible for the poor turn out of women for hospital delivery that is being overlooked.

Postpartum Care

A qualitative systematic review showed that postpartum practices and rituals are common worldwide. They include practices such as rest for the mother, diet restrictions or modifications and different forms of hot baths as were seen in this study [21]. It also suggested that these practices may have implications for clinical practice in regard to postpartum care. In Nigeria, other studies found similar results on postpartum practices as the ones in this study [22,23].

Conclusion

The study revealed that women in this community have misconceptions about food consumed during pregnancy for the wrong reasons. Home delivery was found to be unacceptably high with pertinent factors influencing home delivery, one of which is the birth positions they are compelled to take in the health facilities against their desired positions in addition to financial constraints and harsh treatment from health care providers.

Recommendations

We therefore recommend targeted health education for women of reproductive age through behavioural change communication to correct the misconceptions on food taboos during pregnancy and negative birth practices among the women in communities. Furthermore, the TBAs should be educated on positive roles they can play in improving maternal health while the option of other birth positions should be explored and allowed in the health facilities to accommodate every woman as much as is compatible with safe delivery.

Table 1: *Socio-Demographic Characteristics of The Respondents*

CHARACTERISTICS	FREQUENCY (n = 253)	PERCENTAGE (%)
AGE GROUP		
15-24	48	19
25-34	93	36.8
35-44	63	24.9
>45	49	19.3
MARITAL STATUS		
Divorced	3	1.2
Married	242	95.7
Single	8	3.1
TYPE OF FAMILY		
Monogamous	187	74.8
Polygamous	63	25.2

EDUCATIONAL STATUS		
Primary	49	19.4
Secondary	79	31.2
Tertiary	25	9.9
None	100	39.5
TRIBE		
Berom	232	91.7
Others (Angas, Yoruba, Igbo)	21	8.3

TABLE 2: *Food Restrictions / Taboos During Pregnancy*

PRACTICES	FREQUENCY	PERCENTAGE (%)
Traditional food/medication recommended		
Yes	214	84.6
No	39	15.4
Total	**253**	**100**
Types of food/medication consumed during pregnancy		
Herbs (Tulup, Biryayan)	73	38.3
Carbohydrate	19	1.4
Protein	41	19.2
Fruits and Vegetables	81	27.9
Total	**214**	**100**

Food/medication forbidden during pregnancy		
Yes	121	47.8
No	132	52.2
Total	**253**	**100**
Type of food/medication forbidden in pregnancy		
Meat	63	52.1
Some fruits and Vegetable	10	8.2
Herbs and Leaves	32	26.4
Others (Sugar, Pepper)	16	13.2
Total	**121**	**100**
Reasons for restriction of food/medication – To avoid:		
Bigger babies	87	72.3
Congenital anomalies	25	21.0
Preterm labor	3	1.7
Still Birth	6	5.0
Total	**121**	**100**

Table 3: *Birth practices*

Practices	Frequency	Percentage (%)
Place of last delivery		
Home	187	74.2
Hospital/Clinic	66	25.8
Total	**253**	**100**

Attendant at last delivery		
Doctor/Nurse (skilled attendant)	76	31.1
TBA	100	39.5
Relatives (Mothers, In-law, Aunties)	78	30.4
Total	**253**	**100**
Reasons for home delivery		
Culturally not acceptable to deliver in the hospital	1	0.5
Do not like the position women take to deliver	12	6.4
Lack money for Hospital Delivery	110	58.8
Lack of transport facilities	15	8.0
Poor attitudes of health care providers	49	26.2
Total	**187**	**100**
Preferred birth position		
Lying with back	108	42.7
Sitting	31	12.3
Squatting	114	45.1
Total	**253**	**100**
Special procedures during delivery		
Yes	131	52.2
No	122	47.8
Total	**253**	**100**
Type of procedure		
Back Massaging	93	71.0
Head gripping	22	16.8
Sitz Bath	4	3.1
Others (Insertion of herbal leaves inside vagina)	12	9.2
Total	**131**	**100**

Table 4: *Postpartum Care/Procedure*

VARIABLE	FREQUENCY	PERCENTAGE
Prescribed activity after delivery		
Bed rest	54	21.3
Fluid food	68	26.9
Hot bath/wankan jego	116	45.8
Others	15	5.9
Total	**253**	**100**
Type of food consumed after delivery		
Tuwa acha	151	59.7
Fruit & vegetable	22	8.7
Herbs	19	7.5
Meat	61	24.1
Total	**253**	**100**

Biblliography

1. WHO. Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. 2014; ISBN 978 92 4 150722 6.

2. Dike, P. (2013). Birth practices of Nigerian women: A literature review. *African Journal of Midwifery and Women's Health, 7*(1), 39-48.

3. Nkwocha, E. E. (2007). Maternal crises and the role of African men: The case of a Nigerian community. *African Population Studies, 22*(1), 35-56.

4. Maternal Health Task Force. The Sustainable Development Goals and Maternal Mortality.

5. Ebuehi, O. M. & Akintujoye, I. A. (2012). Perception and utilization of traditional birth attendants by pregnant women attending primary health care clinics in a rural Local Government Area in Ogun state, Nigeria. *International Journal of Women's Health, 4*, 25-34.

6. Jemal, Y., Tedla, M., Tilahun, N. & Dawit, S. (2010). Revisiting the exclusion of traditional birth attendants from formal health systems in Ethiopia. *AMREF Discussion Paper Series, 3.*

7. WHO. (2004). Global Action for Skilled Attendants for Pregnant Women. Geneva: WHO.

8. Envuladu, E. A., Agbo, H. A., Lassa, S., Kigbu, J. H. & Zoakah, A. I. (2013). Factors determining the choice of a place of delivery among pregnant women in Russia village of Jos North, Nigeria: achieving the MDGs 4 and 5. *Int J Med Biomed Res, 2*(1), 23-27.

9. Santos-Torres, M. I. & Vásquez-Garibay, E. (2003). Food taboos among nursing mothers of Mexico. *Health Popul Nutr., 21*(2), 142-149.

10. Quiroz, D. & van Andel, T. (2015). Evidence of a link between taboos and sacrifices and resource scarcity of ritual plants. *J Ethnobiol Ethnomed, 11*(5).

11. Ekwochi, U., Osuorah, C. D., Ndu, I. K., Ifediora, C., Asinobi, I. N. & Eke, C. B. (2016). Food taboos and myths in South Eastern Nigeria: the belief and practice of mothers in the region. *J Ethnobiol Ethnomed, 12*(7).

12. Nejimu, B. Z. (2015). Food Taboos and Misconceptions Among Pregnant Women of Shashemene District, Ethiopia. *Science Journal of Public Health, 3*(3), 410-416.

13. Nnam, N. (2015). Improving maternal nutrition for better pregnancy outcomes. *Proc Nutr Soc., 74*(4), 454-459.

14. Bianchi, C. M., Mariotti, F., Verger, E. O. & Huneau, J-F. (2016). Pregnancy requires major changes in the quality of the diet for nutritional adequacy: simulations in the French and the United States populations. *PLoS One, 11*(3), e0149858.

15. Ramakrishnan, U., Grant, F., Goldenberg, T., Zongrone, A. & Martorell, R. (2012). Effect of women's nutrition before and during early pregnancy on maternal and infant outcomes: a systematic review. *Paediatr Perinat Epidemiol, 26(*s1), 285-301.

16. Taddese, A. Z., Melaku, U. & Kaleab, B. (2016). Dietary habits, food taboos, and perceptions towards weight gain during pregnancy in Arsi, rural central Ethiopia: a qualitative cross-sectional study. *Journal of Health, Population and Nutrition, 35*, 22.

17. Oshonwoh, F. E., Nwakwuo, G. C. & Eklyor, C. P. (2014). Traditional birth attendants and women;s health practices: A case study of Patani in Southern Nigeria. *Journal of Public Health and Epidemiology, 6*(8), 252-261.

18. National Population Commission (NPC) [Nigeria] and ICF International. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria; Rockfield, Maryland USA, 2014.

19. Harry Oxorn. (1986). Oxorn-Foote Human Labor and Birth. (University of Ottawa, Ontario, Canada, McGraw-Hill Professional Publishing).

20. Best Labor and Birth Positions.

21. Dennis, C., Fung, K., Grigoriadis, S., Robinson, G., Romans, S. & Ross, L. (2007). Traditional postpartum practices and rituals: A qualitative systematic review. *Women's health (London, England), 3*(4), 487-502.

22. Iliyasu, Z., Kabir, M., Galadanci, H. S., Abubakar, I. S., Salihu, H. M & Aliyu, M. H. (2006). Postpartum beliefs and practices in Danbare village, Northern Nigeria. *Journal of Obstertrucs and Gynaecology, 26*(3), 211-215.

23. Ekanem, A. D., John, M. E., Ekott, M. E. & Udoma, E. J. (2004). Post-Partum Practices among Women in Calabar, Nigeria. *Tropical Doctor, 34*(2), 97-98.