Cultural Diversity in Childbirth Practices of a Rural Community in Southern Nigeria

Ekpoanwan E Esienumoh1, Idongesit I Akpabio1 and Josephine B Etowa2
1Department of Nursing Science, University of Calabar, Calabar, Nigeria
2School of Nursing, University of Ottawa, Ottawa, ON, Canada

Abstract

Introduction: Knowledge of cultural diversity is important for nursing/midwifery care as these address ethnic and racial differences between providers and consumers of health care, thus, can strengthen and broaden the healthcare delivery system. In a typical nurse/midwife-patient/client encounter globally, there is interplay of three Cultural systems namely, culture of the nurse/the profession, culture of the patient/client and that of the health care system. Multicultural nature of Nigeria influences birth practices. This paper presents findings of a ‘fact-finding’ phase of action research project which explored understanding of childbirth practices as part of prevention of maternal mortality study in a rural community.

Methods: Ethnography design was utilized informed by participatory action research. Data were generated through twenty-nine in-depth individual interviews of childbearing-age women, four focus group discussions with other childbearing-age women, menopausal women/mothers-in-law and traditional birth attendants. Practices of five traditional birth attendants and one midwife were observed. Participants were selected through purposive and snowball sampling.

Results: Thematic data analysis revealed diversity in childbirth practices between the traditional indigenous culture and nursing/midwifery culture depicted in the following themes: children having children; nutritional taboos; imposition of decision on care; preference for traditional birth attendants; spirituality as source of safe childbirth; position for delivery; utilization of traditional sanitary towels; care in delivery emergencies; midwives ethnocentrism and culture-imposition. Findings were inputted into the planning phase of the action research for critical reflection and action.

Conclusion: Cultural diversity explicitly exists in the nurse/midwife and client interaction in this setting. It is recommended that nurses/midwives should deliberately seek to understand the culture of the people and adopt the harmless ones. Where culture is inimical to health, clients should be democratically and collaboratively motivated to critique their practices with the hope of possible repudiation. This study has implication for the provision of culturally competent care in childbirth.

Keywords: Culture; Diversity; Culture-sensitivity; Childbirth cultures; Midwives culture; Midwifery

Introduction

Cultural diversity refers to the differences between people based on shared ideology and valued set of beliefs, norms, customs and meanings evidenced in a way of life [1]. UNESCO described cultural diversity as the common heritage of humanity and that it is as necessary to humankind as biodiversity is for nature. This concept is regarded as ethical imperative that promotes respect for dignity of the individual [1,2]. Knowledge of cultural diversity is important at all levels of nursing and midwifery care as this addresses ethnic and racial differences where applicable. Additionally, such knowledge can strengthen and broaden the healthcare delivery system through conceptualization of illness and development of treatment models.

It is acknowledged globally that in a typical nurse/midwife-patient/client encounter, there is interplay of three cultural systems namely, the culture of the nurse/the profession, culture of the patient/client and culture of the setting. Therefore, nurses and midwives have to be culturally competent to facilitate the delivery of good quality healthcare in settings with diverse health values and practices [3]. With about 374 ethnic groups, Nigeria is marked by people with diverse cultures [4] which consequently create a challenge to the healthcare providers. These cultural variations also are thought to influence birth practices. Diversity in birth practices is also globally acknowledged in literature. A review of phenomenological studies on the meaning of childbirth in various parts of the world which included America, Scandinavia, the Middle East, China and Tonga revealed cultural implications of pain-coping mechanisms among the women [5]. These authors concluded that it is fundamentally important to understand culturally bound behaviours in order for nurses to facilitate satisfying birth experiences for culturally diverse women. In Africa, studies in Nigeria and Ghana have also revealed a strong influence of cultural beliefs of the people on childbirth processes and maternal mortality [6-8].
Theoretical Framework

This study is supported by ‘Culture care: Diversity and Universality Theory’ propounded by Leininger. The goal of this theory is to provide culturally congruent holistic care. This means that care must be in harmony with an individual or group’s cultural beliefs, practices and values. Culture simply means learned, shared and transmitted values, beliefs, norms and ways of life of an individual or group that guide their thinking, decisions, actions and patterned ways of living. To ensure culturally congruent care, the following elements must be present in the nurse-client relationship [9]:

- Nurse and client should creatively design a new or different care lifestyle for the well-being or health of the client. This requires the use of generic and professional knowledge.
- Care knowledge and skills are re-patterned for client’s best interest.
- The implication is that the client is a co-participant with the nurse/midwife to identify, plan, implement and evaluate care.

This process enables nurses to design nursing actions and decisions using culturally based knowledge to provide meaningful holistic care that is satisfying to individuals and groups [9].

In highlighting some assumptions in this theory, Leininger emphasized that every human culture has folk remedies, professional knowledge and professional care practices that vary. Based on this, it is important that the nurse or midwife identifies and addresses these issues in a participatory manner with the client(s) to provide culturally congruent care that improves client’s wellbeing. This allows for cultural care accommodation or negotiation between the client(s) and the nurse/midwife in the effort to attain goal of optimal health outcome.

Therefore this paper presents a study which explored childbirth practices in a rural community in Southern Nigeria and their diversity from the nursing/midwifery culture. It is the report of a fact-finding phase of participatory action research on the prevention of maternal mortality. The objectives of the study were to:

- Gain an understanding of the cultural beliefs and practices surrounding childbirth in a rural community in southern Nigeria.
- Determine the diversity in childbirth practices between the traditional indigenous culture and the nursing and midwifery culture in a rural community in southern Nigeria.
- Provide baseline information for planning an action to promote culture-sensitive care in the rural community in southern Nigeria.

Methods

Study area

This community is located in the central part of Bakassi and has a population of about 8000 people. It is administered traditionally by the community leader, supported by the members of the Council of Chiefs. There is also a Women leader who mobilises the women whenever there is any activity that requires them such as health education and political activities. Although she is not a member of the Council of Chiefs, her position is recognised by the community. This women leader’s opinion is highly respected in the community.

The setting is a relatively small, vibrant commercial community and the major occupations of the people include petty-trading and subsistence farming. The major ethnic group here is the Efik, though there are the Ibibios, Annangs, Ijaw and Ibos who live here to do some business. These various ethnic groups share some common cultural similarities.

The only source of contemporary health care is the Health Centre located in the outskirts of the community and is accessible through a lonely, bushy and untarred road which is difficult to access at night because of darkness. This health facility has not been fully functional for the past fifteen years and no maternity services have taken place during those years due to non-utilization by the women. There is only one midwife and two Community Health Extension Workers in the Health Centre. Due to the inadequacy of staff, the services at the health facility are limited to only 8 a day that is from 8:00 AM to 4:00 PM on week days and does not offer any service on Saturdays and Sundays. Alternative maternity services are provided by the seven traditional birth attendants (TBAs) in this community. Some of the Churches also attend to maternity needs of the women but through unskilled attendants. In addition, such Churches get the TBAs to work for them in this regard.

Design

Ethnography design was utilized in this study under a broader participatory action research paradigm. The ethnography was used to identify the culture of the participants while action research aims to elicit problems through fact-finding, proffer solutions and take action for mitigation.

Inclusion Criteria

The participants selected for this study were as follows:

- Women of childbearing age (15-49 years)
- Menopausal women/mothers-in-law
- Traditional birth attendants
- Skilled birth attendants (Midwives)

Sampling

Participants with the required experience and information were selected from the inclusion criteria through purposive and snowball sampling since this study is exploratory and non-generalisable.

Ethical Issues

Permission was obtained formally from the Ethics Committee of the School of Nursing, Midwifery and Social Work in the University of Manchester, Unite Kingdom, the Cross River State Ministry of Health and the Bakassi Local Government Council as well as the officer in charge of the Health facility in that rural community. Further approvals were obtained from the Community Leader and from the individuals that participated in the study. The patriarchal nature of the families was acknowledged with regard to access to female participants where necessary.

Data Generation

Data were generated through in-depth individual interviews of twenty-nine women of childbearing age to gain understanding of their cultural beliefs and practices on childbirth. Four focus group discussions were held with some other women of childbearing age, menopausal women/mothers-in-law and traditional birth attendants.
Observations of five traditional birth attendants and one midwife in their places of practice were also undertaken.

Data analysis

Audio tapes of the interviews and focus group discussions were transcribed by the secretary [10]. Since the interviews and Focus Group Discussions were conducted in the local dialect (Efik), the translation and transcription were done by a secretary who understands both the local dialect (Efik) and English very well. For technical and conceptual accuracy, thus enhancement of rigor, the transcribed interviews and Focus Group Discussions from the audio tapes (written in English) were read through by an independent person and translated back to Efik for credibility and conformability (as was used for the interviews and FGD) [11,12]. These were compared with the recorded interviews and FGDs in the audio tapes, to ensure that the transcription was correct. In recognition that the Efik language used for the study like most other languages, does not have adequate vocabulary to match the health care language [13], a health professional with midwifery background was engaged to do the back translation.

Following the transcription of the data, they were fed into the NVivo8 software for faster organization into codes and categories. Consequently, thematic data analysis was undertaken. The process involved coding of the key concepts into categories and themes.

Findings

Differences in birth practices between the traditional indigenous culture and nursing/midwifery culture depicted in the following themes emerged: i) children having children; ii) nutritional taboos; iii) imposition of decision on care; iv) preference for traditional birth attendants/mode of care; v) spirituality as source of safety in childbirth; vi) position for delivery; vii) utilization of traditional sanitary towels; viii) care in delivery emergencies; ix) midwives ethnocentrism and culture imposition. The findings were inputted into the planning phase of the action research project for critical reflection and action.

i) Children having children

There were a number of study participants below the age of 13 years at first pregnancy. Some participants’ perspectives on age at first pregnancy revealed the acceptance of child pregnancy from a very young age of 12 years as a norm.

'I became pregnant when I was 12 years old and I had the baby, so I feel that at age 12, a girl is old enough to start having babies. Children are gifts from God and he gives these to people at any age' (Int. 17).

'In my opinion, at age 13 years, a girl is matured enough to get pregnant. After all I was 13 years old when I had my first pregnancy' (Int. 8).

The women mostly hold that a girl could get pregnant from the age of 12 years.

ii) Nutritional taboos

It does appear that TBAs also perpetuate food taboos as a result of superstitious belief, as an example, the comment below illustrates that.

'Heavy loss of blood after delivery could be caused by what the pregnant woman eats. Things like Bournvita (a brand of chocolate drink) and milk…if things like that are too much it can make the child too big. I advise pregnant women to avoid these' (TFG6.02).

Similarly, during observation, another TBA said that she advises the pregnant women not to drink milk.

'I discourage pregnant women from drinking milk…so they would not have big babies' (TBA3).

Some other foods forbidden during pregnancy were discussed by some participants.

'There are some foods that when eaten by a pregnant woman, will make the baby too big, for example ogi (corn porridge) and Bournvita (a brand of chocolate) and beans, these are forbidden in pregnancy' (OWNFG3.01).

'…beans, Bournvita can cause a baby to be too big' (OWNFG3.01).

iii) Imposition of decision on care

Women exclusively are the ones who get pregnant but in the study setting, most of them do not participate in decision-making concerning their care. Significant members of the family take decisions that are binding on the women. Below are responses from some of the women about such decisions.

'My husband decides where I should have my babies. He tells me to go to the TBA' (Int. 1) 'My husband decides where I have my babies' (Int. 13).

'My sister’s husband told me to go to the TBA although my husband did not support the idea. However, I had to obey my sister’s husband by going to the TBA for care' (Int. 5).

In a rare occasion, the decision about place of health care was decided by both the husband and wife.

'It is always an agreement between my husband and I that I should go to the TBA. My husband does not like the hospital' (Int. 2).

The clergy in some Churches make the decision for the woman as to where to have her baby as stated below.

'The pastor of my Church decides that I have my babies in the Church. The Pastor's wife attends to me during delivery' (Int. 3)

Mothers are also involved in the process in which the decision-making for their pregnant daughter though married.

'I have my babies with the TBAs as decided by my mother' (Int. 7).

'My mother and husband usually decide where I should have my babies' (Int. 10).

In spite of the control by others in the majority of cases, a few women expressed that they take decision by themselves about where to have their babies.

'I take the decision about where to be delivered of my babies. It is either in the Church or at the TBAs though my husband prefers the Hospital' (Int. 12).

Most pregnant women are not involved in decision-making concerning their health care. Such decisions are imposed on them by their husbands and others.
iv) Preference for traditional birth attendants/mode of care

The participants attend a variety of places for care during pregnancy and delivery. These include both the traditional and contemporary health facilities. Most of the women interviewed, 18 out of 29, were attended by TBAs.

'I had all my seven children at the TBAs' (Int. 3).

A participant expressed that she gives birth to her babies in the Church.

'I usually have my babies in the Church attended to by the Pastor's wife' (Int. 3).

The view of the skilled birth attendants is that the members of the community do not attach importance to hospital delivery (attendance by professionals).

'The women do not attach importance to attending health facilities like Health Centres and Hospitals where there are skilled birth attendants. They are mostly attended to by TBAs' (DMW.FG8.02).

Observation showed that herbal enemas characterize the antenatal care by TBAs. These are said to serve as preventive measures against heavy bleeding following delivery (postpartum haemorrhage) and also ward off the attacks by evil spirits.

'Routinely, I give the women certain herbs for enema during pregnancy to prevent haemorrhage after delivery. Also in labour, I administer a special enema made of a concoction of herbs and 'ndom' (type of clay) to the woman to prevent heavy bleeding after delivery' (TBA 3).

'Two types of enema are given, the first (mbit mbit ukebe) is given to last for five days every two weeks to prevent abortion or heavy bleeding after delivery, then, from the seventh month of pregnancy, the second type (ukebe mkpokobi) is given to protect the woman from evil powers. These are all herbal enemas' (TBA 4).

'Spirituality as source of safety in childbirth

Some participants opined that prayers can prevent maternal mortality.

'The woman should attend the Church regularly to pray to have her baby….' (MLMWFG7.01).

‘…prayer should be made to God to protect pregnant women from every evil’ (Int. 29).

Based on the firm belief in prayers by the participants, another participant recommended collaboration among the clergy, midwives, doctors and the TBAs as a measure to prevent maternal deaths.

'TBAs, doctors, midwives and the clergy should work in collaboration to prevent our women from dying in childbirth' (CFG4.03).

v) Position for delivery (childbirth)

Data from observation showed that making women lie on the floor or ground to have their babies is a common practice by the TBAs.

‘… I use this lobby for delivery. Occasionally, when the weather is dry, I take delivery in the bathroom at the back of the house. In either of the places, I spread a waterproof material on the floor for the women to lie to have their babies. In some cases, I place a flat sheet of wood in a slanting position for the women to be in a semi sitting-up position for delivery’ (TBA 1).

‘When the weather is dry, I prefer to deliver the women in the open space behind my house. I spread a waterproof mat on the ground for that purpose but in the wet season; I do it in one of the rooms in my house’ (TBA 4).

'I spread waterproof material on the floor of my living room to conduct delivery' (TBA 2)

A midwife corroborated that the women traditionally prefer to lie on the floor to have their babies.

'Some of the few women who come to the hospital for delivery, prefer to lie on the floor to have their babies and they feel very uncomfortable when midwives persuade them to be delivered on the couch' (DMW.FG8.02).

vi) Utilisation of traditional sanitary towels

The women commented on their practice regarding the post-delivery vaginal bleeding (lochia). Many of them are still using the traditional pieces of old cloths while a few use sanitary or perineal pads.

'I use pieces of old cloths as perineal pad; sometimes I also use sanitary pads when I can afford it. When I use pieces of cloth, I wash with soap and dry them in the line behind the house so that I can reuse them' (Int. 1).

'When I was having my babies, I used pieces of cloth as perineal pads because I did not know anything about sanitary pads sold in the shops. I took care of the pieces by washing and drying them close to my bed in the room or outside at the back of the house or on the roof top (Int. 2).

Traditionally, old pieces of cloth which are reusable are accepted as perineal pads in the post-partum period.

vii) Care in childbirth emergencies

The following describe the actions taken by the participants in the event of sudden health problems in pregnancy and process of childbirth. All the 29 women of childbearing age interviewed opted for the hospital in emergencies.

‘In emergency, the woman should go to the hospital so that a doctor can examine her to know the position of the baby in the womb’ (Int. 20).

Alternative plan were also discussed where it is thought that the woman might not afford the bills of hospital care. Other places to attend included the TBAs’ as well the Patent medicine dealer's for off the counter medicines.

‘A woman who has problems in pregnancy should go to the hospital for help. If there is need for a test, this would be done and treatment given to her. Those who are not financially capable should go to the TBA. Alternatively, they could consult a Patent medicine dealer (vendor of over the counter medicines) in the community who would prescribe and sell some medicines to them’ (Int. 3).

It was also found during observation, that the TBAs do not readily refer women with complications to the hospital. Though some of them claim that they do not have need to refer the women, one also stated
that she first of all tries out her remedies and only refers when such remedies fail.

‘I have never had need to refer any woman to the hospital except for once when another TBA referred a woman who had been in labour for two days to me. I tried everything I could but failed, so I referred her to the hospital...’ (TBA 3).

‘...I once encountered a woman who bled late in pregnancy, I gave her a special enema and the bleeding did not cease so I asked her husband to take her to the hospital’ (TBA 3).

viii) Midwives ethnocentrism and culture imposition.

This theme described the practice of midwives in this setting who use subtle coercion on the women to carry out instructions about their care. This means that the women are not being democratically involved in making inputs in their care. Such instructions are mostly based on the midwife’s perspective. For example, it was observed in this study that midwives instruct the women to adopt position for childbirth that is not in conformity with their tradition, such as lying down to give birth instead of squatting or sitting slantlying.

‘Midwives persuade them (the women) to be delivered on the couch’ (DMWFG8.02).

Discussion

Birthing practices identified in this community and their diversity with the nursing/midwifery culture are hereby presented based on the themes previously presented which include: children having children; nutritional taboos; imposition of decision on care; preference for TBAs; care in childbirth emergencies and Midwives ethnocentrism.

Children Having Children

Many of the participants had said that from the age of twelve years, it was safe for a girl to start having babies. The women supported their opinion by their personal experiences because some of them claimed that they started having babies from age twelve and thirteen. From obstetrical perspective, pregnancy in a girl below eighteen years is classified as a ‘high risk pregnancy’ because girls within this age group have been found to present with maternal complications which include eclampsia, obstructed labor and complications of unsafe abortion [14]. A survey in Nigeria revealed that 50% of the maternal deaths occurred in adolescents [14]. In this study, women who had their babies at the age of twelve and thirteen might find it difficult to understand why this age is classified as high risk. However, these women did not disclose if they had complications or not. Although such early teenagers, particularly, those aged 14 years and below, are at a higher risk, literature suggests that not all of them would die of complications in pregnancy and childbirth because of some technological support for provision of specialized care during these periods [15].

In view of this community which is already resource-poor, the teenage mothers may not be as lucky because of all the odds working against them which include poor nutrition due to taboos and lack of proper health-care resources. The norm of early teenage pregnancy in this community is at variance with the accepted norm of nursing/midwifery which views such pregnancies as high risk. Therefore, this finding has implication for community education to raise the awareness on the possible complications of teenage pregnancies.

Nutritional Taboos

The practice of nutritional taboos deprives the women of essential nutrients. Whereas, beans and snails are widely available and affordable sources of protein and okro is cheap and available source of vitamins and mineral salts. Other sources of protein which include, meat, poultry and fish are expensive and so, may not be easily affordable, given the socio-economic status of the members of this rural community who express that they are poor. Thus, food taboos have the implication of malnutrition which could serve as a predisposing factor to severe anaemia, thus making the woman more susceptible to postpartum haemorrhage and sepsis after delivery [16]. This traditional practice places the pregnant woman’s health in a critical situation and contradicts the norm of contemporary practice which emphasises adequate intake of all the classes of food to ensure good nutrition in pregnancy [17]. This finding supports the impact of culture on nutrition as corroborated by some other authors [18,19]; it also requires intervention to educate the community on nutrition in pregnancy.

Imposition of Decision on Care

While the pregnant woman is the one that will give birth, the decision about her care was found to be mostly under the control of other people [20]. The decision about choice of place of healthcare was mainly the prerogative of the husbands followed by other significant extended family members such as mothers/mothers-in-law as well as the Pastor and his wife. These persons mostly advised on the use of TBAs’ services. Such power relations in Nigeria were also observed by some Nigerian authors [20,21]. However, this power relation is not consistent across all of Nigeria because better educated women are more likely to be autonomous [22]. Some authors found similar male dominance in the study of maternal mortality in Ethiopia, India and Tunisia [23]. Studies in Nepal have suggested power relations also between mothers-in-law and daughters-in-law [23]. Mothers-in-law were found to have a strong influence on the uptake of health services because they see themselves as key decision-makers in perinatal care [24]. Such key role played by these persons is an important factor to consider in the provision of maternity care in this setting. Thus, these categories of persons should be involved in community education to enhance maternity care.

Preference for TBAs and their Mode of Care

Most women in this setting were attended by TBAs during pregnancy and childbirth while some were attended by their Pastor’s wife playing the role of a TBA in the Church. The care by the TBAs as shown is characterised by provision of special herbs for enema both antenatally and during some obstetric emergencies. This scenario is typical of health-seeking behaviour by pregnant women in rural parts of Nigeria. Some authors found that the quality of health service as perceived by the community, exert influence on the choice the women make to use it for delivery [25]. In a study of another rural community in Nigeria, it was also found that most women preferred being attended by TBAs to skilled attendants [22]. Other studies also observed that some women had their babies in the church [20,26]. As already mentioned, about 67% of births in Nigeria are attended by unskilled birth attendants [27]. Only very few out of all the women of childbearing age interviewed, were attended to by skilled birth attendants. Contrarily, the World Health Organization recommends
that pregnant women should be attended by skilled birth attendants and care should be of optimal quality [28].

However, the choice of the place of care during pregnancy and childbirth has been found in this study to be influenced by some factors which include the people’s cultural belief. Other studies revealed that perception of the etiology of pregnancy-related problem was a major deciding factor in the choice of place for healthcare, for example, if the problem was thought to have spiritual or traditional origin such as witchcraft or other evil spirits, the people believed that such would be best handled by traditional healers and spiritualists [7,29,30]. Data showed that the members of the community believe that pregnancy is the period in a woman’s life when she is most vulnerable to attack from evil spirits through the manipulation of wicked persons.

The implication of this is that, since most of the women in this community are attended by unskilled birth attendants, they are at a higher risk of dying due to childbirth than those attended by skilled attendants. Some researchers found that women who were attended by unskilled attendants had 3.5-fold more complications than those attended by skilled attendants [31]. This practice being based in culture of the people calls for ideology critique of their culture by members of the community [32], community education and probable integration of the TBAs into contemporary healthcare system by collaboration with midwives [33].

That the TBAs and Church attended to most deliveries in this setting was a sensitive issue because this was observed to be influenced by the cultural beliefs of the people. It is noted that attacking a cultural belief can result in resistance [34,35]. To avoid resistance, it is recommended that mediation should not explicitly condemn the TBAs and the church for undertaking midwifery roles, rather, emphasis in the community education and TRA education should be on the causes of maternal deaths and how they could be prevented based on evidence. This approach through community education is based on the proposition of Blumer that meanings have the potential of being changed during the process of interaction [36].

**Spirituality as a Source of Safety in Childbirth**

Certain religious beliefs and practices were found to be common among the women.

Based on the belief that the pregnant woman is vulnerable to attack of evil spirits, as mentioned previously, in some churches pregnant women are out rightly discouraged from hospital births/attendance by skilled birth professionals through ‘prophecy’ that they would die if they did that. Such churches proffer the provision of spiritual security to the women through subjecting them to fasting for about twelve hours daily for about seven to fourteen days at a stretch. These practices prevent the pregnant woman from seeking the services of skilled birth attendants.

Religious pronouncements are unquestionably accepted because they are believed to be sacred and portray a sense of certainty [37]. Some authors observed that prophetic warnings from the Spiritual Churches injected fear of spiritual attack into the pregnant women, thus making them not seek the care of skilled birth attendants [26]. Subjecting the pregnant women to fasting deprives them of adequate nutrition which is required to support the physiological demand of pregnancy and childbirth [38]. The practice of discouraging the women from utilising the services of skilled birth attendants exposes them to unskilled attendants which increase their risk of dying due to childbirth. As observed, more maternal deaths occurred in church than at the TBAs [26].

It was also identified in this study that prayer is considered to be an important belief held by the people for the prevention of maternal mortality. This suggests their deep religious inclination. Another author also found that childbirth was identified as a spiritual event. This suggests that spirituality should not be overlooked in client care [39]. It is recommended that prayers should be encouraged because it is not a harmful practice, in as much as it is not coupled with fasting for the pregnant women. This implies the provision of care that is culture-sensitive in order to attract the members of the community to utilise the services of the skilled birth attendants [39,40].

**Position for Childbirth**

As revealed in the study, TBAs assisted birthing with the women lying on the floor/ground or being in a semi sitting up position. Consequently, due to their previous experience with the TBAs, such women when in the care of skilled birth attendants were found to also prefer to be attended on the floor in the hospital. This could constitute diversity to a midwife who is used to bed-births. Although taking delivery on the floor may sound crude in some settings and coupled with poor hygiene in the birth environments of some TBAs, floor birth position promotes the recommendation that the birth attendant should fit around the woman rather than the woman fitting around the attendant [41]. This suggests greater independence, self-direction and control for the woman. Meta-analyses on positions of giving birth concluded advantages for the upright position to include: shorter second stage; fewer episiotomies; fewer assisted births; less severe pain; bearing down easier and fewer fetal heart abnormalities [42]. These advantages were also corroborated by more authors [43]. Owing to the advantages of these positions, to be culture-sensitive, the birth attendant/midwife should fit around the woman while ensuring adequate hygiene.

**Utilisation of Traditional Sanitary Towels**

Traditionally, some women in this study used old pieces of cloth that were reusable as sanitary pad in the post natal period. This is a potential source of bacterial infection. Contrarily, the nursing/ midwifery culture advocates the use of well packaged disposable perineal pads (sanitary towels) so as to prevent infection. Bacterial infections around the period of childbirth are one of the causes of maternal mortality. It has been observed that women who experience postpartum infection may suffer long term disabilities such as chronic pelvic pain, blocked fallopian tube with consequent infertility [44].

**Care in Childbirth Emergencies**

Although most of the participants utilised the services of unskilled birth attendants during childbirth, there was a consensus to seek help from skilled birth attendants when complications occur. This finding corroborates that of other authors who found that women with major maternal complications were referred to skilled birth attendants in public healthcare facilities [22]. However, it was also found that the TBAs in this study did not readily refer the women until they had tried out their remedies and failed, thus resulting in delayed referral. Delayed referrals by traditional birth attendants have been discussed in literature. Traditional birth attendants, who claim that the source of their skills is through inheritance, do not readily refer their clients [45].
This practice by the TBAs is inimical to maternal health, whereas skilled birth attendants would readily adopt emergency obstetric care measures to remedy the situation [15]. This situation requires tact by the skilled birth attendants not to condemn the TBAs but try to win them over through education with the presentation of scientific evidence.

**Midwives Ethnocentrism and Culture Imposition**

In this context, the midwives subtly display ethnocentrism by imposing the culture of bed birth on the women instead of fitting to the woman. This is contrary to the recommendations in the theory of Birth Territory propounded by Fahy and Parrat which has jurisdiction as one of the key concepts. Jurisdiction refers to having power to do as one desires in the birth environment and comprises the following: integrative power; disintegrative power; midwifery guardianship and midwifery domination. Integrative power harnesses the powers of the woman in labour, the midwife and all others in the birth environment to support the woman. This means that the woman needs to make informed decisions about her care options through the support of all others around her. This has been found to enhance the woman's mind-body integration leading to her self-expression and confidence as a major player in what is happening with her thus may lead to spontaneous childbirth [46]. Midwifery guardianship works to guard the woman and her birth territory. On the contrary, midwifery domination is a form of disintegrative and ego-centered, disciplinary and manipulative power which undermines the woman's decision-making power. Midwives need to guard against being ethnocentric; otherwise, this could lead to resistance by their clients [46].

As discussed previously, the findings of this study presented in the themes are clear demonstration of the diversity of the beliefs and practices of members of this study setting from the nursing/midwifery culture. This confirms the assumptions of Leininger in her 'Culture care: Diversity and Universality theory' that such variations exist in every human culture. Participatory approach between the client (community) and nurse/midwife recommended by the proponent of this theory to provide care that is culturally congruent is similar to the participatory approach of Action Research on which this study is based. Data were collaboratively generated with selected members of the community in the fact-finding phase. Eventually, these findings would be fed into the subsequent phases of planning, action and evaluation. It is anticipated that in the planning phase, proposed actions would skilfully incorporate clients/community beliefs and values as well as current research findings to ensure that care is customised to that community. For example, children having children, nutritional taboos, preference for TBAs, care in childbirth emergencies might likely be re-patterned by members of the community following therapeutic actions facilitated by the nurse/midwife.

**Conclusion**

It is concluded that cultural diversity explicitly exists in the nurse/midwife and client interaction in this setting. Therefore, to create a positive impact on maternal care, nurses, midwives and other healthcare providers should deliberately seek to understand the cultural values and practices of the people and adopt the harmless ones. This would require flexibility in professional practice. Where the culture is inimical to health, the health providers should democratically and collaboratively through therapeutic action motivate the clients to critique their practices with the hope of possible repudiation or re-patterning. This study has implication for the provision of culturally competent care for women of childbearing age with hope of consequent attainment of desired positive health outcomes for both mother and baby.

**Significance of the Research**

Cultural diversity refers to the differences between people based on shared ideology and valued set of beliefs, norms, customs and meanings evidenced in a way of life [1]. UNESCO described cultural diversity as the common heritage of humanity and that it is as necessary to humankind as biodiversity is for nature. This concept is regarded as ethical imperative that promotes respect for dignity of the individual [1,2]. Knowledge of cultural diversity is important at all levels of nursing and midwifery care as this addresses ethnic and racial differences where applicable. This is particularly so in this era of globalization. Additionally, such knowledge can strengthen and broaden the healthcare delivery system through conceptualization of illness and development of treatment models.

It is acknowledged globally that in a typical nurse/midwife-patient/client encounter, there is interplay of three cultural systems namely, the culture of the nurse/profession, culture of the patient/client and culture of the setting. Therefore, nurses and midwives have to be culturally competent to facilitate the delivery of good quality healthcare in settings with diverse health values and practices [3]. With about 374 ethnic groups, Nigeria is marked by people with diverse cultures [4] which consequently create a challenge to the healthcare providers. These cultural variations also are thought to influence birth practices. Diversity in birth practices is also globally acknowledged in literature. A review of phenomenological studies on the meaning of childbirth in various parts of the world which included America, Scandinavia, the Middle East, China and Tonga revealed cultural implications of pain-coping mechanisms among the women [5]. These authors concluded that it is fundamentally important to understand culturally bound behaviors in order for nurses to facilitate satisfying birth experiences for culturally diverse women. In Africa, studies in Nigeria and Ghana have also revealed a strong influence of cultural beliefs of the people on childbirth processes and maternal mortality [6-8].

To the best of our knowledge, although studies of some contexts in Nigeria identified influence of cultural beliefs on pregnancy and childbirth, none has explored the differences between the cultural practices of healthcare providers and consumers. Therefore, this is an original research that has generated knowledge to highlight the diversities in childbirth practices between the indigenous traditional culture and that of nurses/midwives in Southern Nigeria. The knowledge is also expected to inform the development of active health care policies for the improvement of maternal health outcomes through provision of culture-sensitive care.

**Acknowledgement**

The authors express their thanks to members of the community and health professionals who participated in this project especially, Chief Archibong Adim, Pastor Effiong Obong, Mma Ikana Ukpabio, Mma Margaret Joseph, Asari Archibong, Glory Etefia, Mma Roseline Effiong, Oluseun Olarewaju, Iquo Ekpo, Theresa Esuabanga, Mary Umoh and Dorothy Odo.
References