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Prevalence of Cultural Malpractice and Associated Factors among Women Attending MCH Clinic at Debretabor Governmental Health Institutions South Gondar, Amhara Region, North West Ethiopia, 2015

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Abstract

Introduction: Every day, at least 1.600 women die worldwide from the complication of Pregnancy and child birth, 90% of which occurring in Asia and Sub Saharan Africa. These shows, maternal death in developing country is higher than developed countries. One of the contributing factors for these problems is cultural malpractices practiced during pregnancy, child birth and post natal periods. The actual incidence of cultural malpractices in developing country accounts for about 5-15% of maternal deaths. The objective of the research was to assess prevalence of cultural malpractice and associated factors among women attending MCH clinic at Debretabor Town governmental health institutions South Gondar, Amhara region North Ethiopia 2015 G.C.

Methods: An institution based cross-sectional study was employed. Systematic sampling was used to select 355 study participants. A pre tested and structured questionnaire was used to collect data. The data was entered, cleaned and edited using EPI INFO version 2002 and exported to SPSS version 20 software packages for analysis. Both bivariate and multiple logistic regression were fitted and odds ratio and 95% CI were computed to identify associated factors and determine the strength of association. A p-value of <0.05 was considered as statistical significant.

Results: A total of 355 mothers participated with response rate of 100%. The prevalence of cultural malpractice was found to be 25.6%.Ggrand para (AOR 3.466: 1.926, 6.236) was factors significantly associated with cultural malpractice among mothers attended MCH clinic.

Conclusion and recommendation: The prevalence of cultural malpractice in the study area was found to be high. Grand shows significant association with cultural malpractice among mothers attended MCH clinic. So, high effort needed to be worked on this target population.

Keywords: Malpractice; Culture; Prevalence; Mother child clinic

Introduction

Throughout human history, societies have had particular perceptions of health and disease rooted in their own culture which have led to a plurality of practices for disease prevention and cure especially during illness, pregnancy and child birth [1].

Traditional practice represents the sum total of all behaviours that are learned, shared, and transmitted from generation to generation such as language, religion, types of food eaten and method of their preparation, child bearing practices, handling of children and aged person, and other values that hold peoples together and give them a sense of identity and distinguish them from other group and categorized as harmful or beneficial based on its harmfulness to the physical nature of a human being, psychological and social needs [1].

Ethiopia is a country of famous and long-standing history with its own identity. It is also a country with many useful and promotional traditions traditional practices those includes breast feeding, post natal care, social gathering such as “Eder”, “Shengo”, “Ekub”, caring for the aged person, children and religious leader [2]. On the other hand, it is a country where harmful traditional practices are commonly practiced during different events and age group especially females and children which includes home delivery, abdominal massage, food taboo, early marriage, marriage by abduction, giving “kosso”, application of cow dung on the umbilicus, keeping babies out of the sun, son preference, unsafe abortion, usage of herbal drug [2,3].

Despite significant investments in resource, targeted interventions are aimed at achieving the millennium development Goals, minimal progress has been made in reducing maternal mortality and extreme inequality remains study between those who die and survive among women in the developing world still dying from child birth related causes [4].

The suggested reason for minimal progress are violence and trauma, lack of control over reproduction, malpractice during pregnancy and child birth, low social status, gender discrimination, lack of educational opportunities for girls and lack of awareness in ANC follow up [4,5].

Culture is that which is socially acquired and transmitted or shared characteristics of a given group, community, society and nation which can affect the health of the individual in several ways. For example, women in developing countries, especially in rural areas, work for more than 12 hours in a day in the field of agricultural work, marketing, labor work and different home work during their pregnancy, breast feeding and PNC time. Besides this, there will different cultural influences

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which affect the heath of pregnant women such as food taboos, herbal drug usage, abdominal massage and hardworking during pregnancy and child birth [6-8].

Cultural malpractices during pregnancy and childbirth are the common practices in the developing countries like Ethiopia due to the lack of precise [9].

In Ethiopia, culturally, the pregnant women avoid milk, honey, meat and some valuable food staffs in order to avoid a large baby and difficulty of labor, abdominal massage to relieve back pain and to correct the position of the fetus mostly by UTBA. In addition to this, different herbal medicines or drugs such as koso, duba are taken in many regions as treatment for some pregnancy and pregnancy related symptoms which have serious effect on health of the mother as well as on fetus which may leads to IUFD. In addition, the pregnant woman does extraneous working activity until the last trimester of pregnancy because of believes that it will help to make the labor easier and reduce the body weight of the infant [6,10].

Also majority of women deliver at home (90%) following the cultural birth customs which creates problem that they couldn't overcome for several years [11,12].

Methods

Institutional based cross sectional study was conducted among Mothers attend MCH clinic in Debretabor town Governmental health institution. The study was conducted in Debretabor town which is located in south Gondar, Amhara Regional state Northwest Ethiopia. Debretabor town has total population of 78703 (37682 male and 41021 female). There are 3 governmental and 4 private health institutions in the town. The study was conduct from February to March, 2015.

The study populations were all women attending MCH clinic services during the study period. All women attending MCH clinic services during the study period were included in the study.

Systematic sampling was employed to select study participants from each health institution. By considering average numbers of clients who attended MCH clinic daily during data collection period was estimated based on the previous daily client flow of the units was obtained by referring client registration book/ record for a month prior to data collection.

Using single population proportion formula the finally sample size was found to be 355.

Data was collected by face to face interviews using a structured and pre-tested questionnaire. Training was given for both data collectors and supervisors. Data entry was done by using EPI Info 2002 and exported to SPSS version 20 software package for analysis. Multivariate logistic regression was fitted to determine the effect of various factors on the outcome variable. The degree of association between independent and dependent variables were assessed using odds ratio with 95% confidence interval.

Ethical clearance was obtained from Institutional Review Board (IRB) of University of Gondar. Formal letter of cooperation was written for Debretabor Woreda health department and each health institution. Verbal and written consent was obtained from each study participant.

Results

Socio-demographic characteristics

A total of 355 participants were included in the study and response rate was 100%. Majority of the respondents 279 (78.6%) were found the year between 20-35 and the least 9 (2.5%) were less than 20 years. Almost more than half of the participants 319 (89.9%) were orthodox followed by Muslims 30 (8.5%). Among the participants 353 (99.4%) were Amhara followed by 2 (0.6%) tigre. Majority of the respondents 236 (66.5%) were housewife and the least 11 (3.1%) were student. Most of them 34 (96.3%) were married and the least 2 (0.6%) were unmarried. Among the respondents 148 (41.7%), 93 (26.2%), 67 (18.9%), 47 (13.2%) were illiterate, primary school, college and above and secondary school respectively.

Obstetrics history

From355 respondents 250 (70.4%) had no history of home delivery but 105 (29.6%) of respondents delivered at home. Most of women delivered at home are assisted by their family 46 (13%). Among home deliveries 91 (25.6%) cut the cord using unboiled new blade and 18 (5.1%) do not tie cord after delivery. 43 (12.1%) of mothers had abdominal massage during pregnancy. 162 (45.6%) had history of food prohibition during their pregnancy and 193 (54.4%) had no history of food prohibition. Most of the respondents 213 (60%) have started breast feeding within one hour, 109 (30.7%) within 24 hours and 33 (9.3%) after 24 hours.

Two factors associated with cultural malpractice

In multivariable logistic grand para (AOR 3.466:1.926, 6.236) were significantly associated with cultural malpractice with p-value<0.05.

Grand para women were three times done cultural malpractice when compare with women delivery less than five.

Discussion

In this study proportion of cultural malpractices was 25.6%. Grand multipara women are factors significantly associated with cultural malpractices.

WHO estimated that about 70% birth in developing world in given preceded by a single ANC visit nearly 38 million women receive no ANC. On average only 53% births were skilled health professional. In the present study 74.4% women delivered in health institution. When we come to our country ETHIOPIA about 28% practice abdominal massage during pregnancy.

According to EPHTI manual on HTP for health care team uterine massage during 2nd stage of labor by TTBA, UTBA, relatives, neighbours are kneading and squeezing women abdomen with intention of inducing labor. This act may cause excessive bleeding, uterine rupture and incomplete placental separation.

According to cross sectional study conducted in North Gondar 2010, 30% mother had abdominal massage in attempt to facilitate labor, to correct malposition of the fetus and also about 23.3% of the mother who delivered at home umbilical cord was not tied. When we compare this to our study abdominal massage is 43 (12.1%) and mothers who do not tie umbilical cord 18 (5.1%) which is lower.

While according to cross sectional study conducted in Jimma town Agaro zone on 384 women 2010 shows us abdominal massage 37.4%, cutting umbilical cord with unsterile material 2.08%. In the present study instrument used to cut umbilical cord at home delivery 10 (2.8%) boiled new blade, 91 (25.6%) unboiled new blade and 2 (0.6%) used unsterile blade which is lower than study conducted in Jimma town Agaro zone.

Culturally pregnancy often has restricted their food intake mainly

due to morning sickness which is believed to be prevented by eating limited type of food. And also due to the believe that large fetus cause obstructed labor will result from eating unrestricted amount and type of food item. Thus pregnant women restrict her food intake in order to avoid large baby and difficult labor. According to our study 162 (45.6%) have food prohibition during pregnancy.

Grand multipara women were three times done cultural malpractice as compare with women not in grand multipara women this might be grand multipara women accepted cultural malpractice from the previous generation.

Conclusion

The prevalence of cultural malpractice in the study area was found to be high. Grand shows significant association with cultural malpractice among mothers attended MCH clinic. So, high effort needed to be worked on this target population.

Competing Interests

The authors declare that they have no competing interests.

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