



CULTURAL DIVERSITY IN CHILDBIRTH PRACTICES IN A RURAL COMMUNITY IN SOUTHERN NIGERIA

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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.
- Knowledge of cultural diversity is important at all levels of nursing/midwifery care as it addresses ethnic and racial differences where applicable.
- Cultural knowledge can strengthen and broaden the healthcare delivery system through appropriate conceptualization of illness and development of treatment models.



Introduction (continued)

- 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 (organizational culture).
- Diversity in child birth practices is a global phenomenon.
- Therefore, nurses and midwives have to be culturally competent to facilitate delivery of good quality healthcare in settings with diverse health values and practices (Etowa & Adongo, 2007).
- Etowa, J. & Adongo, L., (2007). Cultural Competence: Beyond Culturally Sensitive Care for Childbearing Black Women. *Journal of the Association for Research on Mothering*. 9.2:73-85,

Aim



- The aim of this paper is to present the study that explored the cultural birth practices of community members in a rural area in Southern Nigeria and their diversity from the nursing and midwifery culture.



Research Objectives



- To gain understanding of the cultural beliefs and practices in childbirth in a rural community in southern Nigeria.
- To determine the diversity in childbirth practices between the traditional indigenous culture and the nursing and midwifery culture in a rural community in southern Nigeria.
- To provide baseline information for planning and action to promote culture-sensitive care in the rural community in southern Nigeria.





Methods

Study setting

- The community is located in the central part of Bakassi LGA and has as a population of about 8,000 people.
- Administered traditionally by the community leader with members of the Council of Chiefs.
- Women leader mobilises the women for educational and political activities.
- This community has one contemporary Health Centre .
- Alternative maternity care is provided by seven traditional birth attendants (TBAs) and several 'Churches'.
- Most of the people are petty-traders and subsistence farmers.

Methods (continued)



Research Design

- Ethnography design was utilised in this study under a broader action research paradigm.

Inclusion criteria

1. Women of childbearing age (15 – 49 years)
2. Menopausal women/mothers-in-law
3. Traditional birth attendants
4. Skilled birth attendants (Midwives)



Methods (continued)

- **Sampling**

- Participants with the required experience and information were selected from the inclusion criteria through purposive and snowball sampling.

- **Ethical issues**

- Approval was obtained from the Ethics Committee of the School of Nursing, Midwifery and Social Work in the University of Manchester, United Kingdom, the Cross River State Ministry of Health and other gate-keepers.



Methods (Continued)

- **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 (Table 1).
- Observations of five traditional birth attendants and one midwife in their places of practice were also undertaken.



Table 1: Focus Groups

Participants	Number
Younger women of childbearing age (15-22 years)	6
Older women of childbearing age (23-49 years)	8
Mothers-in-law/menopausal women	9
Traditional birth attendants	6



Methods (Continued)

- **Data analysis**

Since the interviews and Focus Group Discussions were conducted in the local dialect (*Efik*), the transcription and translation of the audio tapes were done by a secretary who understands both *Efik* and English very well (Halcomb and Davidson, 2006).

- For technical and conceptual accuracy, thus enhancement of ***rigour***, the transcribed data (written in English) were read through by an independent person and translated back to *Efik* for ***credibility and confirmability*** (as was used for the interviews and FGD) (Esposito, 2001; Squires, 2009).



Data Analysis (continued)

- These were compared with the recorded interviews and FGDs in the audio tapes.
- In recognition that the *Efik* language does not have adequate vocabulary to match the health care language (Fredrickson, Rivas, and Whetsell, 2005), 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 organisation into codes and categories.
- Consequently, thematic data analysis was undertaken.
- The process involved coding of the key concepts into categories and themes.

Findings



- Diversity in birth practices between the traditional indigenous culture and nursing/midwifery culture categorized into the following nine themes emerged:
 - i. child pregnancy;
 - ii. nutritional taboos;
 - iii. imposition of decision on care;
 - iv. preference for traditional birth attendants/mode of care;
 - v. prayer as source of safety in childbirth;
 - vi. position for delivery;
 - vii. utilisation of traditional sanitary towels;
 - viii. care in delivery emergencies;
 - ix. midwives ethnocentrism and culture imposition.
- The findings were integrated into the planning phase of the action research project for critical reflection and action.

Findings:



- **Child pregnancy**

- The participants' perspectives on age at first pregnancy revealed the acceptance of child pregnancy from a very young age of 12years as a norm.

- **Nutritional taboos**

- TBAs also perpetuate food taboos as a result of superstitious beliefs, for example: 'I discourage pregnant women from drinking milk ... so they would not have big babies' (TBA3).



Findings:

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



Findings:

Preference for TBAs/ mode of care

The participants received care during pregnancy and delivery from a variety of places.

- These include:
 1. TBAs' (18 out of 29, were attended by TBAs)
 2. Church
 3. Contemporary health facility (Formal health care)

Findings:



Prayer as source of safety in childbirth

- Some participants opined that prayers should be incorporated into maternity care to prevent maternal mortality.
- Another participant recommended collaboration among the clergy, midwives, doctors and the TBAs as a measure to enhance care/ prevent maternal deaths.





Findings:

Position for delivery (childbirth)

- Making the women lie on the floor or ground to have their babies is a common practice by the TBAs.
 - *'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).



Findings:

Utilisation of traditional sanitary towels

- Many of the women are still using the traditional pieces of old cloths as sanitary or perineal pads following childbirth.

Care in childbirth emergencies

- All the 29 women of childbearing age interviewed opted for hospital care in emergencies.

Alternative plans 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' and Patent medicine vendors.



Findings:

Midwives ethnocentrism and culture imposition.

- It was observed that midwives make the women to adopt position for childbirth that is not in conformity with their tradition.

For example: 'midwives persuade them (the women) to be delivered on the couch' (DMW.FG8.02).



Discussion

Child pregnancy

- 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 labour and complications of unsafe abortion (Airede and Ekele, 2003).
- **Nutritional taboos**
- 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 child birth (Okolocha, Chiwuzie, Braimoh, Unigbe, and Olumeko, 1998).



Discussion (Continued)

- **Imposition of decision on care**

- Choice of place of healthcare was the prerogative of husbands and significant others such as mothers/mothers-in-law, Clergy and his wife.
 - These mostly advised on the use of TBAs' services. Such power relations is common in Nigeria (Shehu, 2000; Mboho 2009).
 - These categories of persons should be involved in community education to enhance maternity care.
 - Preference for TBAs is a typical health-seeking behaviour in rural parts of Nigeria (Osubor et al, 2006)

- **Prayer as a source of safety in childbirth**

- This suggests deep religious inclination of the people. It is recommended that this should be encouraged because it is not a harmful practice, in as much as it is not coupled with fasting for the pregnant women.
- It implies the provision of culture-sensitive care. May be adopted by skilled birth attendants to attract the members of the community to utilise their services (Kim-Godwin, 2003).



Discussion (Continued)

- **Position for childbirth**

- Taking delivery on the floor may sound crude in some settings.
- Adopting this position supports the recommendation that the birth attendant should fit around the woman rather than the woman fitting around the attendant (Walsh, 2007).
- This promotes greater independence, self-direction and control for the woman.

- **Care in childbirth emergencies**

- The consensus to seek help from skilled birth attendants when complications occur corroborates the findings of Osubor et.al. (2006).
- TBAs in this study did not readily refer the women until they had tried out their remedies and failed, thus resulting in delayed referral.
- This practice by the TBAs is inimical to maternal wellbeing and constitutes a major source of diversity.



Discussion (Continued)

- **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 women.
- This is contrary to the recommendations of the theory of Birth Territory by Fahy and Parrat (2006) which has jurisdiction as one of the key concepts.
- Jurisdiction refers to having power to do as one desires in the birth environment.
- The woman needs to make decisions about her care options through the support of all others around her.



Theoretical framework

- Leininger (1981) 'Culture care: Diversity and Universality theory' informed the study.
- The goal of this theory is to provide culturally congruent wholistic care and it has the following elements in the nurse-client relationship (Leininger, 1981):
 - 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.

Leininger's (1981) theory of Culture Care: Diversity and Universality



- Every human culture has folk remedies, professional knowledge and professional care practices that vary.
- Nurse or midwife identifies and addresses these factors 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 shared goal of optimal health outcome.

Application of Leininger's theory to our study



- Findings of this study are clear demonstration of the diversity of the beliefs and practices of members of this study setting from the nursing/midwifery culture, thus confirming the assumptions of Leininger that such variations exist in every human culture.



Application of Leininger's theory to this study (continued)

- Participatory approach between the client (community) and nurse/midwife recommended by the proponent of this theory 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.
- These findings would inform the subsequent phases of planning, action and evaluation.
- In the proposed planning phase, actions would incorporate clients/community beliefs and values as well as current research findings to ensure customised care to the community.
 - For example, Child pregnancy, 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

- Cultural diversity explicitly exists in the nurse/midwife and client interaction in this setting.
- To create a positive impact on maternal care, nurses/midwives and other healthcare providers should deliberately seek to understand the culture 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.
- This study has implication for the provision of culturally competent care for women of childbearing age.