Original Article

Anthropology

Role of Traditional Birth-practices causing Maternal and Neonatal Mortality in Faisalabad: An Anthropological Approach of Household Decision Making

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ABSTRACT

Background: Anthropology is a holistic science that targets the study of man in its social, cultural, economic, psychological, political, geographical and ecological settings. Anthropology views major's interventions in areas of health to be planned with the complete cognizance of cultural factors that largely effect the target populations regarding their participation in all such major interventions. The Social Impact Assessment (SIA) referred by Anthropology basically demand scientific verifications of all such hurdles that may later on impede the acceleration of such heavy funded programs.

Objective: The objective of the study was to investigate the decision-making regarding Safe Child Birthing Process among pregnant females and role of their in-laws.

Study Design: Cross Sectional Study

Place and Duration of Study: This study was commissioned to the research team on behalf of Pakistan National Council on Ageing (PNCA) based in Islamabad. The data collection was done in the BHU of Chak # 474 GB, Tehsil Samundari, District Faisalabad. The study duration was three months and lasted from July 2012 to September 2012.

Materials and Methods: Structured questionnaire was developed to collect information on child birth practices as well as opinion of females of respective sample area. In this regard, an extensive questionnaire was designed and pre-tested vigorously. Questionnaire contained bio-informatics including demographic information of clients and the second part covered areas of decision making, role, agents and other stakeholders. Questionnaires were filled with the help of LHVs and LHWs after getting the permission from their senior authorities.

Results: Results show that 29.2% of the respondents were illiterate, while 33.4% of the respondents pass their primary education. Ratio of birth attendant at last delivery was 58.1% for TBA/Dai and 17.2% respondents used the services of doctor for delivery proposes. Mother-in-law was the most influential decision maker in the family. As result explains that, for antenatal visit 118 time, for normal delivery 135 times and for EmONC 128 times decision taken by mother-in-law (n=267).

Conclusion: The decisions regarding child birth largely remain a female issue and rest with the mother-in-law mostly. The second dominant agents are husband and the father-in-law/brother-in-law. On statistical level, the result show strong association between clients and in-laws. The study verifies that the para-medical staff is also required to get training on the importance of cultural factors and means to convince the target population with threatening their cultural mind-set. A complete cognizance of such cultural variable may lead to promotion of safe child birthing as well as contributed in reducing the maternal mortality rates among the rural women.

Key words: Safe Birthing, Dai, Traditional practices, Decision making, maternal and neonatal mortality

INTRODUCTION

Maternal mortality is the leading cause of death among women of reproductive age in developing countries.[1] There are an estimated 4 million neonatal deaths and 500,000 maternal deaths worldwide each year.[2,3]

Most maternal and infant deaths occur for reasons that are preventable through simple medical technology, antenatal care, awareness and better access to health services. Untrained traditional birth attendants who deliver 80 percent of babies in Pakistan cannot provide these services. The maternal mortality rate of females is 150 per 100, 000 live births in the district which is high as compared to 3 per 100, 000 live births in developed countries. This higher maternal mortality rate is due to malnutrition in females, too many kinds of work, violence against females, short intervals between births etc. The infant deaths are also primarily the result of poor maternal health and nutrition, inadequate coverage of pregnant women with immunization and

complications during delivery. Malnutrition of children starts early in childhood and is also related to poor feeding practices.[4]

As we all knows about the 4th and 5th MDG is paying attention to reduce neonatal mortality and improve maternal health. This research was focused on the decision making during the period of pregnancy, labor pain to delivery and in EmONC cases. This study was to collect the opinion of female respondents in current scenario. Research was more focused to collect data on decision making which further increase or decrease the rate of mother and neonatal mortality.

Prompt decision-making is a prerequisite for reducing delay to seek care.(5,6) Decision-making on utilization of health services is related to women's autonomy, which is defined by Hindin as women's ability to make decisions in the household.[7,8] whereas in south East Asia it is mostly mother-in-laws who determine the location of birth.[9]

The "Three Delays" model of maternal mortality by Thaddeus and Maine highlights the role of the health system and the community in maternal deaths. The three delays that result in maternal deaths are: 1) delay in deciding to seek care, 2) delay in reaching the healthcare facility where emergency obstetric care (EOC) is available and 3) delay in initiation of treatment after arrival at the EOC facility.[10]

It is argued that low levels of individual autonomy amongst women in Pakistan results in poorer health outcomes, in that women are unable to make decisions regarding the need for care, and accessing healthcare services. In the Pakistan Rural Household Survey (2001), an overwhelming number of women reported that they needed permission to visit a health facility.[11]

Null Hypothesis: the two criteria (person and client) are independent.

Alternative Hypothesis: the two criteria (person and client) are not independent i.e, they are associated.

MATERIALS AND METHODS

For this research, BHU Chak # 474 GB, Tehsil Samundari, District Faisalabad was selected. The catchment population of BHU is 20438. By using 90% level of confidence, error margin 5% with response distribution 52%, sample drawn was 267. All females of BHU catchment population had an equal chance for getting selected as respondent. After taking permission, from concerned health authorities LHVs and LHWs were involved in the process of data collection. Firstly, LHVs and LHWs were trained on specific structured questionnaire. A pre-test was done before the implementation of the tool in similar environment to improve the tool before real data collection. LHVs and LHWs did field visits to collect the data after taking verbal consent of each respondent. Questionnaire's first part was based on the basic demographic information of respondents and second part consisted questions to cover the opinion of respondents about decision making, their involvement in decision making, how in-laws participated in decision making with reference to particular situations, what was the role of respondent's husband or other male members of HH in such decision making process.

RESULTS

Education is a major source of information in every society at each level. Evidences show that the literacy rate amongst rural female was not appropriate and was too low. As table 1 figures explain the education level of respondents. Figures show 29.2% respondents had no education at all, 33.4% got the primary level education, 16.1% raised their education up to secondary class level , 13.5% were able to complete their intermediate and only 7.8% respondents passed BA and above education.

Table No.1: Level of Education of respondents (n=267)

Category	Frequency	Percentage
Illiterate	78	29.2%
Primary	89	33.4%
Secondary	43	16.1%
Intermediate	36	13.5%
B.A above	21	7.8%
Total	267	100%

Table No.2: Birth Attendant at the time of Last Delivery (n=267)

Category	Frequency	Percentage
Doctor	46	17.2%
LHV	39	14.6%
Mid-wife/Nurse	27	10.1%
TBA/Dai	155	58.1%
Total	267	100%

Table.2 shows the trend of respondents towards the utilization of birth provider for delivery. The data show that still 58.1% cases were delivered by TBA/Dai. 17.2% of the respondents delivered their last baby under qualified Doctors' consultation, 14.6% used the services of LHVs and 10.1% respondents visited Mid-wives/nurses for delivery purposes. Skilled attendant is defined, based on the joint WHO/UNFPA/ UNICEF/World Bank statement as: People with midwifery skills (for example doctors, midwives, nurses) who have been trained to proficiency in the skills necessary to manage normal labor and deliveries, recognize the onset of complications, perform essential interventions, start treatment, and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in the particular setting.[12] Overall, only about 30 percent of pregnant women in Pakistan receive any antenatal care and less than 20% deliveries are conducted by trained health professional.[13]

Table No.3: Permission required for going to Hospital in case of antenatal visits, normal delivery and EmONC (n=267)

Person	For Antenatal Visits	For Normal Delivery	For EmONC
Husband	38	48	87
Mother-in-law	118	135	128
Father/brother-in-law	95	63	30
No permission required	16	21	22

Table. 3 since the calculated value of Chi-square is 59.156 falls in the critical region, we therefore reject our null hypothesis of independence and conclude that the data provide evidence of a statistical association between the two criteria of classification between person and client. Jafarey and Karejo suggest that economic, social and cultural factors play a more defining role in maternal deaths than medical causes.[14].

DISCUSSION

The majority of women deliver babies attended by a family member or a traditional birth attendant (TBA), who often lack the knowledge to detect danger signs, let alone respond skillfully to complications with drugs, such as oxytocics to stop bleeding.[15] History of rural areas shows that the average concept about the safe birthing was not appropriate to control the death ratio among both mothers and neonatal cases. They (rural communities) took this issue as routine matter and do not bother to take it seriously. Pregnancy and delivery are the routine issues and the family elders especially females prefer births to be looked after by the of traditional birth attendants (Dai) to deliver baby and take care of pregnant women by using their traditional methods. This ambitious goal that has potential to save thousands of lives, sets a steep challenge for South Asia as only 35 percent of births in the region take place with the attendance of skilled care, the lowest rate in the world despite the huge population size.[16] The percentage is slightly higher in India, with 35 percent of births attended by TBAs, and just over 40 percent attended by health professionals.[17]

The ability to make a timely decision to seek care can also be compromised due to inadequate knowledge of danger signs by women and their husbands.[18] Majority of the evidences seen in previous records and studies verify that at the time of emergency the transport is not usually available, therefore majority of pregnant women were not able to access the health facilities in time. During night timings in rural areas, lack of transport facility is a grave reason for maternal mortality. If somehow, transport is available but it is reported that it is not comfortable enough to carry a pregnant woman to health facility. Low awareness of the required steps towards a safe delivery can lead to unhealthy behavior. Not making prior transport arrangements and therefore having to use uncomfortable transport like a rickshaw or quingqi are reflective of poor preparedness and have been reported by others.[19]

Global reappraisals of program strategies to reduce maternal mortality clearly indicate that all pregnant women are at risk of obstetric complications. A high maternal mortality reflects the need for addressing women's health in Pakistan. The role of the health sector in improving maternal health is to ensure availability of quality essential obstetric services to all women during pregnancy and childbirth.[10] Social and cultural factors play an important role to increase or decrease the ratio of maternal mortality. In urban areas, trends are more changed and developed regarding maternal health and other related issues. While rural areas were inclined towards their cultural and traditional patterns. In rural culture, it is more common to deliver a baby by using their traditional methods and seeking advice from traditional medical practitioners like Dai, Siyani and they (respondents) were more inclined to follow their cultural practices due to family elders. In some areas of rural Pakistan, more than 90% of deliveries are performed by untrained or semi-trained Traditional Birth Attendants.[20]

CONCLUSION

The purpose of the paper was to study the decision-making regarding the safe child delivery among the females of the rural areas. For this aim, the BHU of Chak # 474 GB in Tehsil of Samundari, District Faisalabad was selected. The study rectifies that most cases of child delivery and resultant decision making incline towards the traditional methods and attendants. As regards, the child delivery, the role of mother-in-law largely dominates such decisions, after that husband and father-in-law remain the second highest among the decision-quartile. In this regard, the female's paternal side remains invisible in majority of the cases, whereas in some cases their role was merely supervisory. It was also noted that the classified programs aimed at created awareness on mother and child health issues are putting their level high to promote safe child birthing practices but anrothropologically speaking severe lack of understanding regarding importance of cultural factors in case of child birth remain the big hurdle for all such programs to score low in spreading awareness especially in most critical situations or emergencies. The qualified health personnel need to be trained effectively on how to treat with the cultural and traditional mind-sets of people in rural areas in order to promote safe birth practices and thus reducing the major causes of maternal mortality in rural areas of Pakistan.

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