

Safe Motherhood Practices among Child Bearing Mothers (CBMs) in Nsukka Urban of Enugu State, Nigeria

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Abstract

Purpose: The study examined safe motherhood practices among women of childbearing age in Nsukka urban area of Enugu State.

Design/Methodology/Approach: The descriptive survey research design was used for the study. The instrument for data collection was the self developed questionnaire. The population of the study consisted of all resident childbearing mothers (CBMs) in Nsukka urban area. A sample of 137 CBMs was drawn from selected health centres and hospitals in the urban area. The research questions were answered using percentages while the only postulated hypothesis was verified using chi-square analysis.

Findings: The result of the analysed data using the 50 per cent cut off approved by the WHO International standard indicated that nutritional practices (36.4%) was inadequate while immunisation and personal hygiene practices (52.1% and 69.0%) were adequate respectively. The chi-square analysis on the influence of the educational level of CBMs on safe motherhood practices ($p < 0.5$) was accepted.

Implication: Results implicate the need for health educators, institutions and other health professional to design better educational strategies to improve health education practices among CBMs in the area of study.

Originality/Value: The value of this work resides on the critical recommendations that among other things, seminars and workshops should be organized for CBMs to improve their safe motherhood practices especially in the area of nutrition.

Keywords: Child Bearing Mothers, Enugu, Nigeria, Practices Safe motherhood

Paper type: Empirical

Introduction

Safe motherhood refers to a situation in which a woman going through physiological processes of pregnancy and child birth does not suffer any injury or lose her life or that of the baby (Action Health, 1999). According to World Health Organization – WHO (2000) safe motherhood is a worldwide initiative whose aim is to reduce maternal morbidity and infant mortality and to improve women's reproductive health. Similarly, Partnership for Transforming Health Care System – PATHS (2005) views it as concerned efforts by a pregnant woman herself, her family members (immediate and extended), her community and all health personnel at the three tiers of health care system to ensure that safety of a pregnant woman and her baby during pregnancy, delivery and after delivery.

Mahler (2002) stated that safe motherhood is achieved through a concerted set of intervention

designed to reduce maternal mortality and also to improve the reproductive health status of women. Thus, according to her, safe motherhood is aimed at reducing the number of deaths and illness that are associated with pregnancy and childbirth. According to Adesokan (2010) safe motherhood encompasses a broad range of direct and indirect efforts to reduce deaths and disabilities resulting from pregnancy and childbirth and also to improve women's reproductive health. Safe motherhood refers to the application of good health to daily living such as personal hygiene and nutrition in order to ensure that the health of the mother and that of the baby is not jeopardized (Surat, 2002). He further explained that safe motherhood examines strategies and methodologies for keeping

mothers and their babies healthy. Safe motherhood is ensured through effective and

Practices as posited by Hornby (2002) are acts concerned with real situation of doing what is sensible, useful and good at repairing or making things. Similarly, Webster (2004) defined practices as what we do habitually or customarily. Therefore, safe motherhood practices as conceptualized in the present context refers to actions aimed at saving the lives and preserving the health of the women and that of their babies, spanning through pre – conception to antenatal, intrapartum and post-partum periods.

Ajurved (2000) asserted that safe motherhood practices seek to address direct medical cares and undertaken related activities to ensure that women have access to comprehensive reproductive health services. WHO (2000) explained that safe motherhood practices include such services as antenatal care, delivery services such as skilled assistance for delivery with appropriate referral for women who have complication and post natal care services. Surat (2002) had earlier stated that safe motherhood practices are the application of good health to daily living of pregnant women. According to him, they include practices like adequate nutrition, personal hygiene, family planning, immunization practices to mention a few. However, this study focused on three aspects of safe motherhood practices, namely: nutrition immunization and personal hygiene.

UNICEF (2004) opined that for a pregnant woman to safe guard her own health as well as that of the baby, she needs to pay serious attention to her diet. The report further revealed that a woman who is breast feeding needs to drink copious liquid to replace the water provided in the breast milk. A high protein diet is also needed to facilitate breast milk production. The report further indicated that iron and folic acid supplements should be included in her medications during the antenatal care services to prevent anaemia during pregnancy. According to WHO (2004), women should be encourage to eat good and balanced diet during pregnancy because ideal safe motherhood practices begin before conception with proper nutrition and healthy lifestyle. UNICEF (2004) posited that nutritional practices deal with full understanding and use of time for breast feeding,

efficient practise of health care services.

acceptance of colostrums, exclusive breast feeding for six months and correct time for weaning. These, according to the report will provide adequate immunity to both the mother and the baby. Therefore, the process of inducing immunity as a preventive measure against infection is referred to as immunization.

According to Obionu (2006), immunization is the most powerful cost effective means of preventing some of the deadly diseases of childhood as well as being some of the components of primary health care (PHC). A mother or a child who is immune to disease is protected against the disease by means of antibodies. The prevention of disease by immunization, a conventional public health measure is today the best known, practical, low cost, community based way of protecting CBMs and children against the major killer childhood diseases. One of the UNICEF'S strategies for mother and child survival is immunization against six vaccine preventable diseases. This is of particular relevance to developing countries where malnutrition, infections and poverty synergistically cause the majority of maternal and infant deaths. Unfortunately, while it is widely recognized that improved vaccination coverage will dramatically reduce maternal and infant deaths. It is a well known fact that diseases such as measles, poliomyelitis, pertussis, tuberculoses, tetanus and diphtheria cause mortality among infant in many developing countries such as Nigeria today. These diseases are preventable through immunization. According to UNICEF (2008), immunization alone would save three million lives a year. Immunizing a woman with at least two doses of tetanus toxoid before or during pregnancy protects not only the woman but also the child against tetanus of the newborn. The report further indicated that immunization of a pregnant woman has a great impact on the neonatal tetanus mortality than the place of delivery.

Personal hygiene is concerned with matters relating to health of an individual. It can also be said to be the keeping of oneself from disease and infection. Lawoyin (2008) suggest that in order to ensure good and safe health of the mother and her baby, women should endeavour to take their bath at least twice daily, clean their

vagina thoroughly with tepid water and keep their finger nails short so as not to harbour germs and dirt. A certain attitudinal problem was revealed by UNICEF (2000) regarding hygiene issues in rural and urban areas like the use of latrines, refuse disposal system, good environmental sanitation have drastically deteriorated. The report indicated that there is no improvement in the attitude of pregnant women towards living within clean environment and the maintenance of good health. These attitudinal problems underscore the need to improve health standard through personal hygiene education. Many literatures have explained the health situations of women of childbearing age to be associated with personal hygiene and adequate nutrition.

Adeyemi (2004) stipulated that many women have nutritional deficiencies which contributed to high rate of deaths especially among women of CBMs and this occurs as a result of over consumption of the wrong types of food and the adoption of sedentary life style. Malnutrition makes CBMs more vulnerable to infections and contributes to the intensity of their disease and therefore mortality. UNICEF (1988) stated that under malnutrition contributed to the death of one – third of the 14 million maternal deaths in 1988. The report also revealed that 40,000 under five children die every 24 hours of disease conditions associated with some degree of nutrition. Obionu (2006) reported that malnutrition especially marasmus and kwashiorkor is rampant among CBMs in semi – urban and rural settings of this country Nigeria. According to UNICEF (2003), poverty presents a major developmental challenge and impacts significantly on the health of mothers and their children in many ways.

Poor families have high risk to be malnourished and to be subjected to infections due to unhealthy environment which will compromise their mothers and children health performance, and they are also less likely to use health services and services of health professionals as they may not be able to afford them. WHO (2000) in the report of her study on poverty assessment showed that most telling social characteristics of the poor in Nigeria are exclusion. According to the report, the poor generally suffer exclusion from the labour market as manifested in the perennial and high unemployment rates; exclusion from basic housing and easy access to productive assets, public utilities and exclusion from meaningful

participation in community activities, social life and national development. Malnutrition is due to multiple socio-economic problems and is associated with the level of development of a country. It could be in recognition of the above literature assertions that Obionu (2006) stated with emphasis that adequate nutrition is an important aspect of safe motherhood practices.

Regrettably, Mahler (2002) stated that as commendable as safe motherhood initiative, many women in Nigeria still portray vapid practices towards it. UNICEF (2003) also posited that there is little or no information on safe motherhood among CBMs in most rural places in Africa. This is the nub of this study. The purpose of the study is to determine safe motherhood practices among CBMs in Nsukka Urban of Enugu State. Specifically, the study tends to:

- i. determine the nutritional practices among women of childbearing age
- ii. ascertain the immunization practices among women of childbearing age
- iii. identify personal hygiene practices among women of childbearing age

In order to accomplish the task, the following research questions were formulated to guide the study.

- i. What are the nutritional practices among women of childbearing age?
- ii. What are the immunization practices among women of childbearing age?
- iii. What are the personal hygiene practices among women of childbearing age?

HO₁ There is no statistically significant difference on safe motherhood practices among childbearing mothers (CBMs) in Nsukka Urban of Enugu State based on level of maternal education.

Methods

The study adopted a descriptive survey research design. Nworgu (2006) stated that descriptive survey research design is one which aims at collecting data on, and describing in a systematic manner, the characteristics, features or facts about a given population. According to Cohen, Manion and Morriron (2011) descriptive survey research sets out to describe and interpret what is, gathers data at particular point in time with the intention of describing the nature of existing conditions or identifying standards against which

existing conditions can be compared, or determining the relationship that exist between specific events. Therefore, this design was found appropriate for the present study.

A total of 137 CBMs were drawn randomly from the total population of 1371. This is inline with Nwana’s (1990) rule of thumb which stated that when population is in few thousand, 10 percent of the population can be considered as appropriate sampling size.

The self developed research questionnaire made up of four sections based on review of related literature and objectives were used as instrument for data collection. Section A consists of the personal data of the respondents, Section B consists of items on nutritional practices among CBMs, Section C consists of items on immunization practices among CBMs while Section D contains items on personal hygiene practices among CBMs.

Criticisms, advices and suggestions from three experts from Department of Health and Physical Education, UNN were used to modify the instrument. Thus, preliminary content validity

was ensured. Split half method was used as recommended by Ogbazi and Okpara (1994) to ensure the reliability of the instrument. The result yielded reliability co-efficient of .86 as internal consistency using Cronbach’s Alph Statistics. The distributed copies of the questionnaire were collected on the spot of which twelve copies were mutilated, thus not properly completed and therefore rejected. However, 125 (91.2%) return rate was recorded. The completed copies were analyzed using frequencies and percentages.

The criterion for deciding whether or not a practice was observed by CBMs was based on WHO (1999) international standard cut-off point of 50 per cent. Therefore, any table that has a total average of 0 – 49 per cent is considered inadequate practice and any table that has a total average of 50 and above is considered adequate. Chi – square (χ^2) statistics was used to verify the only null hypothesis.

Results

The results were presented in Tables according to research questions and hypothesis.

Table 1: Nutritional Practices among Women of Childbearing Age (n=125)

S/N	Nutritional Practices	f	%
1.	Eating high protein diets during pregnancy and childbirth	84	67.2
2.	Drinking much water and other liquid to enhance breast milk	79	63.2
3.	Weaning before six months	13	10.4
4.	Taking iron and folic acid supplements when pregnant	77	61.6
5.	Combining breast milk and other food	7	5.6
6.	Breast feeding exclusively for 4 – 6 months	27	21
7.	Avoiding certain nutritious food like snail as a result of custom	32	25
	Average		36.4

Table 1 reveals that the nutritional practices among CBMs were considered inadequate (36.4%). However, some items among

nutritional practices met the 50 per cent cut off as recommended by WHO international standard

Table 2: Immunization Practices among Women of Childbearing Age (n=125)

S/N	Immunization Practices	f	%
1.	Immunizing the child with DPT I, II, & III against diphtheria, pertussis and tetanus.	90	72
2.	Immunization against poliomyelitis	80	64
3.	Immunization against Hepatitis type A and B and yellow fever	83	66
4.	Immunization against maternal neonatal tetanus	28	22
5.	Immunization against whooping cough	76	60.8
6.	Immunization against measles	76	60.8
7.	Immunization against tuberculosis	23	18.4
	Average		52.1

Table 2 shows that the immunization practices of CBMs was fairly adequate (52.1%) since it met the above acceptable standard by WHO.

However, practices such as immunization against maternal neonatal tetanus was inadequate (22.4%).

Table 3: Personal Hygiene Practices among Women of Childbearing Age (n=125)

S/N	Personal Hygiene Practices	f	%
1.	Cleaning the breast with salt tepid water solution before breast feeding	60	48
2.	Proper cleaning of the environment	81	64.8
3.	Adequate washing of vegetables, fruits and other food items before consumption	87	69.6
4.	Washing of hands after using the toilet	93	74.4
5.	Bathing twice daily	103	82.4
6.	Covering of cooked food against rodents and vectors	100	80
7.	Use of safe and clean water	41	32.8
	Average		69.0

Table 3 indicates that the personal hygiene practice of CBMs was adequate (69.0%).

However, the use of safe and clean water was inadequate (32.8%).

Table 4: Summary of Chi – square Analysis on the influence of Maternal Education on Safe Motherhood Practices (n=137)

Level of Education Disposition		Nutritional practices	Immunization practices	Personal hygiene practices	Total	df	cal X ²	tab X ²	Decision
No formal Education	O	2	6	12	20				
	E	6.131	5.839	8.029					
Primary Education	O	10	5	7	22				
	E	6.744	6.423	8.832					
Secondary Education	O	15	20	23	58				
	E	17.781	16.934	23					
Tertiary Education	O	15	9	13	37				
	E	11.343	10.802	14.854					
Total		42	40	55	137				Accepted

($\chi^2 = \text{cal } 8.808 < 12.59$, $df=6$, $p, > 0.5$)

Discussion

The discussion is hereby presented under the following subheading.

- Nutritional practices among CBMs in Nsukka urban.
- Immunization practices among CBMs in Nsukka urban
- Personal hygiene practices among CBMs in Nsukka urban

Nutritional practices among CBMs in Nsukka urban.

The findings in table 1 revealed that there were poor nutritional practices (36.4) among CBMs in Nsukka urban. The finding is not surprising as it appears to resemble the poor nutritional practices of most CBMs in Nsukka urban. The findings are in line with Adeyemi (2004) assertion that many women have poor nutritional practices which contribute to high rate of maternal mortality in the area. This perhaps could be the reason UNICEF (2003) had earlier stipulated that poor nutritional practices among

CBMs attributed to increased maternal mortality and major developmental challenges in the health of mothers.

Immunization Practices among CBMs in Nsukka Urban

The findings in table 2 shows that immunization practices (52.1%) were fairly adequate among CBMs in Nsukka Urban. This is really amazing that despite the poor educational level of most mothers, they value the importance of immunization. This finding is in support of UNICEF (2004) which stated that adequate immunization during pregnancy and after delivery would save millions of life yearly. Obionu (2006) agreed that immunization is really the most powerful cost effective means of preventing some of the deadly disease of childhood.

Personal Hygiene Practices among CBMs in Nsukka Urban

The findings in table 3 presented an over whelming result concerning the personal hygiene practice (69.0%) among CBMs Nsukka urban.

This shows that mothers now appreciate the importance of personal hygiene as a preventable tool in health education. The findings were in consonance with Babafemi (2002) who stated that despite the challenges facing women as home carers; they still have skills for positive personal hygiene practices. The findings were expected and should be a heart – warming news to personal hygiene proponent.

The chi – square analysis in table 4 indicated that level of maternal educational had no significant influence on safe motherhood practices of CBMs in Nsukka urban of Enugu State. The findings were surprising and unexpected. However, the finding goes to support Agu's (1999) report that education has no influence whatsoever with the practices of safe motherhood.

Conclusion

Based on the result of the study and discussion, the following conclusions were made:

1. There were inadequate nutritional practices (36.4%) among CBMs in Nsukka urban
2. The immunization practices among CBMs (52.1%) in Nsukka urban were fairly adequate
3. The personal hygiene practices among CBMs (69.0%) in Nsukka urban were adequate.

Recommendation

Based on the findings and discussion, the following recommendation

1. Health educators, institutions and other health professional should design better educational strategies to improve health education practices among CBMs in the area of study.
2. Seminars and workshop should be organized for CBMs to improve their utilization of MCH services.
3. All stake holders including churches, parents and all concerned in child up bringing should be mobilized and sensitized to modify the health education myths among CBMs in the area of study.
4. Institutions should be established to organize, coordinate and fund state and national research on sustainable practice of safe motherhood among CBMs.

5. More research studies should be conducted on factors that hinder practice of safe motherhood among CBMs.
6. Numerous well equipped and staffed MCH clinics should be built by governments at all levels to improve CBMs access to utilization of MCH facilities and services.

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