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Nutrition and Health Believes of Mothers During Pregnancy and Labour

HODA A. HASSAN, M.D., Ph.D.; EFFAT F. NOOR, Ph.D.
and MOHAMED A. HUSSEIN, M.D., Ph.D.

The Department of Nutrition Requirements and Growth and Unit of Data Management and Computer, Nutrition Institute.

Abstract

Rapid assessment procedures were used to study women's knowledge, attitudes and practices regarding antenatal care during pregnancy, care during labour, nutrition and health knowledge in the presence of different kinds of health facilities. One hundred mothers whose last child did not exceed 2 years of age from Menial Shiha village, Giza Governorate were chosen for this study. Fifty eight said that pregnant women do not need care during pregnancy because it is a normal event and so no interference should be done. Only 6 mothers mentioned that immunization is essential for their children to maintain their health. Sixty three mothers preferred delivery at home and are accustomed to be attended by traditional birth attendant (TBA) or (daya) because they feel comfortable and secure. In 47 cases, sister in-law or mother in-law usually attends delivery because they live in the same home. Any sharp unsterilized household tool was used to cut umbilical cord in 61 cases. Sixty mothers delayed breast feeding until the 3rd day after delivery. Seventy-one mothers believed that there was no need for special food during pregnancy, but 77 of them mentioned that large quantities of food should be eaten during pregnancy irrespective of its quality. On the other hand, 37 mothers believed that some foods e.g. fried onion, meat, tea, coffee, pickles should not be eaten or drunk during pregnancy because it was bad for health. Boiled egg was given during labour in 32 cases because it leads to more frequent uterine contraction. Protein foods such as meat and poultry (especially chicken) was offered to 76 mothers immediately after delivery because they believed that the uterus felt sorrow from losing its baby and there must be immediate replacement by chicken.

Introduction

WOMEN'S health is strongly conditioned by the political and economic environment in which they live. A positive relationship between socio-economic status and the ability of mothers to provide adequate food and primary care has been observed [1].

Dietary habits and beliefs influence food consumption pattern and consequently the nutritional status of mother and baby. Melville and Francis [2] reported various dietary changes during pregnancy for a group of 38 pregnant women in rural Jamaica.

Quantitative surveys alone, whether socio-economic or nutritional and dietary are

not enough to give a complete picture of the reasoning the behaviors and beliefs that exist. So, the qualitative anthropological study helped to explain health-related behaviors in those women surveyed that might have gone unnoticed if data gathering had been strictly quantitative.

Because women's own health beliefs and nutritional knowledge status directly affect her child's health during pregnancy, at birth and in the first years of life, this study was conducted to:

1- Identify practices which are potentially or actually deleterious to the health of mothers and infants specifically those which influence pregnancy, labour and their following events.

2- Assess mother's behavior and attitude toward primary health and nutrition care for herself and her child in the presence of the different health facilities available in the village. The available health facilities are health unit, nearby governmental hospital, private clinics and family planning center together with two traditional birth attendants (Daya).

Village characteristics:

This village (Manial shiha) is located about 20 Kilometers from the Center of cairo city. The village has a population of about 19,000. The inhabitants are living in an area of 250 acres, while the land area occupies 2,500 acres. Streets are unpaved. Drainage and sewage systems are either clogged or do not exist. Public transportation is deficient. Garbage collection is absent and disposed in the street or canal.

Material and Methods

A representative sample of 100 mothers in the child bearing period were selected on the basis that their last child does not exceed 2 years of age. Each mother was visited in her house twice for interviewing by researchers.

This study relied on open ended questions which were structured to obtain information on mother's beliefs about nutrition and health during pregnancy and labour; an approach that was developed by Scrimshaw and Hurtado [3] using Rapid Assessent Procedures (RAP) guide lines.

Results and Discussion

I- Village description:

Houses are made either from the traditional mud bricks or red bricks and consist mostly of one flat or may reach up to three. 68% of houses composed of three rooms for various uses. The mean number of bed rooms in 73% of houses was 2.0±1.65. The mean household size was 9.5±5.8.

The source of water in the village is underground water for the daily use except drinking. Because of its turbidity, they obtain their drinking water from public taps that belong to another system of underground water purification project for the village. Females keep drinking water in Zeer (big container made of pottery).

The village is well served by official institutions e.g. veterinary unit, agriculture co-operative unit, post office and police center. The health unit includes outpatient clinic and primary health care center. The village is headed by local village council with an official appointed head.

II- Mother's age and related events:

In rural community certain events during female life is connected with certain age e.g. age of menarche, first marriage age. It was found that the mean age of marriage for girls was 16.5±2.5 years with a range between 12 to 24 years. The average

age of mothers at the first delivery in this study was 18.2±3.65 years. These findings are similar to other developing countries [4,5].

Most of mothers in this study were housewives, (90%) and illiteracy among them was high (83%). This is a common finding in many developing countries [6].

III- Mother's health and nutrition knowledge:

Female rural community has a stable food and health habits, beliefs and traditions which are compatible with survival. As regards the antenatal care, it was found that more than 58% of mothers believed that ante-natal care is not needed except in emergency cases. They mentioned that, pregnancy is a normal event and so no interference is needed. Although the village women had no apparent knowledge about the nutritional value of food, it was found that 25% of mothers considered consumption of meat and poultry during pregnancy is a requisite because these foods are not frequently eaten before pregnancy and costy. Majority of women (71%) did not have preferences for special food during pregnancy and commented, whatever we can get is good for us, so mothers must be kept with full stomach with anything available in house. About the relation between health and food, 77% of mothers asserted that, to remain healthy one must eat large quantities of any available food.

The nutritional status of women is a function of nutrition experiences of childhood and adolescence. So, it affects the childbearing and has an effect on foetal size. 52% of mothers mentioned that, if the mother was well nourished her baby size will be good.

Cultural beliefs that restrict specific foods during pregnancy appear to be widespread through this village. 37% of mothers believed that some foods, e.g. (fried onion, meat, tea, coffee and pickles) shouldn't be eaten during pregnancy. They thought that these foods cause harm for themselves and their babies. Hamilton et al. [7] reported some food restrictions among the third world countries. On the other hand Ware [8] found that some cultures have recognized the increased nutritional needs of women during pregnancy.

Many precautions were mentioned by only 15 mothers who reported some beliefs about getting a healthily newly born baby. These included immunization during pregnancy, rest and avoid receiving any kind of treatment.

Women during child birth don't like to be attended by males. This attitude is carried over to the point that some women will not go to a physician even for prenatal care if only male physicians are available. Traditional birth attendants (TBA) are neighbor women whom they trust and feel comfortable and secure during their presence. 63% of mothers prefer delivery by daya (TBA) at home. Orwell et al. [5] reported the same findings in Nigeria. Brems and Griffiths [9] found similar results in Rwanda with the exception that labour may be attended by any experienced woman or man.

It was apparent from the study that the presence of some individuals during labour e.g., aunt, sister, neighbor give mothers the sensation of tranquility. The most popular attendants in 47% of cases were the sister-in-law or mother-in-law because they usually live with them in the same home.

While certain foods must be avoided during pregnancy others are preferred dur-

ing delivery, to make it easier. Eggs were thought to be good for the mother during delivery and 32% believed that eggs should be eaten because they make uterine contractions more frequent. Also mint, mogat and fenugreek were given to 17% of mothers during delivery. They believe that, these drinks facilitate foetus expulsion. In this village daya is accustomed to use any available tool at home to cut the umbilical cord, Knife, scissors, razors and the handle of the kerosene stove needle were used in 61% of cases. Also, it was found that 69% of mothers apply to the umbilicus-after tying with a string-talc powder, chamomilla oil or kohl. They believed that these substances prevent infection and facilitate its falling. Antiseptic lotions (e.g. dittol and alcohol) were used in 4% only of the sample.

Cultural beliefs that are usually followed to spare the newly delivered mother from usual domestic activities for a certain period are falling away in this village. It was found that 55% of the newly delivered mothers especially those from nuclear families took care of herself and her baby. No body offers any help for her.

Dietary customs after labour were also mentioned. Chicken is usually offered to 76% of mothers immediately after labour. They thought that uterus feels sorrow from losing its baby and so there must be immediate replacement by chicken. Other dietary customs were also reported by Vimala and Ratnaprabha [4] amony tribal mothers of Andhra Pradesh.

Breast feeding and infant feeding practices reflect, to some extent, culturally derived views of when breast feeding should start and why. It was found that the precious value of colostrum was not known to majority of mothers. 60% of mothers delayed breast feeding until the 3rd day after delivery. The mean reason for delaying breast feeding was that, mothers believe that there is no sufficient milk to feed her baby and sugar water is introduced to babies through this period. They thought that sugar water can clean infant's mouth and stomach. This is similar to the findings of Vimala and Ratnaprabha [4] Omotola and Akinyele [10] and Cherian [11]. However, Niehoff and Meister [12] reported the contrary.

About the way by which mother could keep her infant healthy, 71% of mothers mentioned that feeding and changing napkins is enough, while only 6% of mothers considered immunization is an essential factor.

Conclusion:

It was our intention in this study to have an idea about the integrity of maintained traditional and cultural beliefs during pregnancy and labour in rural community. These beliefs may be a factor in causing both matemal and infant mortality and morbidity.

It was clear from this study that:

1- Environmental sanitation is neglected.

2- There is unawareness about the importance of antenatal care, the use of the proper method of cutting the umbilical cord, the importance of immunization and the benefit of early breast feeding.

3- There are still some wrong beliefs about nutrition during pregnancy and labour.

Hence, it is important to consider the existing beliefs in any program of health promotion and disease prevention. So, programs on health and nutrition education should focus on changing and correcting

inappropriate knowledge and harmful practices through all communication channels identified in the community. Health care providers must participate in solving health related problems. In addition to the previous intervention, the presence of unlicenced daya whom they trust in this village must be considered. They should sit on a training practical course under supervision of the health authorities to obtain an official license. By the end of the daya training program dayas should know the essential basis of maternal and child health and should obtain proper skill about ante and post-natal care and delivery. This has been practiced in some other regions in Egypt where the daya was provided at the end with a bag containing the proper tools needed for performing safe labour. This program of training achieved successful results in the respective regions.

References

1- SIMS, L.S.: Demographic and attitudinal correlates of nutrition knowledge. J. Nutr. Educ., 3:122, 1976.

2- MELVILLE, B. and FRANCIS, V.: Dietary habits and superstitions of rural Jamaican women during pregnancy. Europ. J. Clin. Nutr., 46: 373-374, 1992.

3- SCRIMSHAW, S. and HURTADO, E.: Rapid assessment procedures for nutrition and primary health care. Los Angeles: UCLA Latin American center Publications., 1987.

4- VIMALA, V. and RATNAPRAHBA, C.: Infant feeding practices among tribal communities of Andhra Pradesh. Indian Pediatrics, 24:907-910, 1987.

5- ORWELL, S.; CLAYTON, D. and DUGDALE, A.E.: Infant feeding in Nigeria. Ecology of food and Nutrition, vol. 15, pp. 129-141, 1984.

6- WATTS, T.; NG'ANDU, N. and WRAY, J.: Mothers in an urban township in Zambia. J. Trop. Pediatr., 35(3): 117-20, 1989.

7- HAMILTON, S.; POPKIN, B and SPICER, D.: Women and nutrition in third world countries. New York, Praeger, 1984.

8- WARE, H.: Sex differentials in mortality and morbidity. In women, demography and development. Canberra: Australian National University, 35-75, 1981.

9- BREMS, S. and GRIFFITHS, M.: Health womens's way: Leaming to listen. Bulletin on infant feeding and maternal nutrition, vol. 10 No. 3, p. 4-6, 1991.

10- OMOTOLA, B.D. and AKINYELE, I.O.: Infant feeding practices of urban low income group in Ibadan. Nutr. Rep. Int. vol. 31, No. 4, p. 837-847, 1985.

11- CHERIAN, A.: Attitudes and practices of infant feeding in Zaria, Nigeria. Ecol. of Fds and Nutr. 11,75, 1981.

12- NIEHOFF, A. and MEISTER, N.: The cultural characteristics of breast feeding: The Journal of tropical Pediatrics and environmental child health. Vol. 18, No. 1. pp. 16-20, 1972.