

Care of the newborn: Community perceptions and health seeking behavior

Charlotte Warren

Abstract

Background: Every year, 120,000 newborns die in Ethiopia. In 2005 a national Safe Motherhood Community-Based Survey was carried out on behalf of the Family Health Department to explore community practices surrounding newborn health and care seeking behavior.

Objective: To explore and understand health seeking behavior, and identify the positive practices surrounding care of the newborn.

Methods: In-depth interviews and focus group discussions regarding newborn care practices were conducted with mothers, older women, men with young children, health providers, religious leaders and elders across Ethiopia's 11 regions.

Important findings: Tradition recommends mothers and their newborns to stay at home for 40 days. The principle behind the practice, facilitates the period of rest and repair, establishes breastfeeding and is justified on the grounds that the mother and newborn are vulnerable to malevolent spirits. Perceptions of the causes of newborn mortality and morbidity are consistent with those relating to biomedical causes. Many complained of lack of accessible health care that in event of emergencies. Therefore they have to rely on traditional medicine as it is easily accessed, readily acceptable.

Conclusions: When families seek care for their newborns, remedies from traditional healers are often preferred to skilled health workers because of cultural and religious beliefs, poor access to health facilities, (including distance and terrain) and financial barriers. [*Ethiop. J. Health Dev.* 2010;24 Special Issue 1:110-114]

Introduction

Neonatal morbidity and mortality rates in Ethiopia are among the highest in the world and stem from a range of socio-economic, political and demographic factors. Many of these deaths are preventable. Around 120,000 newborns die every year and the neonatal mortality rate is 37 per 1000 live births [1]. Many women do not generally seek formal healthcare during pregnancy childbirth and puerperium. This has a major impact on care seeking for, and survival of, the newborn. Less than a third of women receive antenatal care and 90% are assisted by unskilled attendants; TBAs (26%), relatives (58%), or alone (6%). Almost no one (3.5%) receives any postnatal care (2).

In 2005 a national Safe Motherhood Community-Based Survey was carried out on behalf of the Federal Health Department (FHD) to explore community values and practices surrounding maternal and newborn health, the influences of those values and practices on health seeking behaviour, and the barriers and enablers to seeking and utilizing health services. The survey was carried out across the 11 Regions of Ethiopia in 16 selected sites which represented a cross-section of livelihoods, gender roles and status, and disparity in access to maternal and neonatal health services (see survey report for detail of sites)[3]. Following the production of the final report of the Safe Motherhood Community based Survey (SMCBS), Population Council was requested by JSI/LTK project to carry out more in-depth analysis of the data from four of the regions: Amhara, Oromiya, Tigray, Southern Nations, Nationalities and Peoples Regions (4, 5, 6, 7).

High fertility levels are sustained by cultural preferences for large families, and reinforced by low awareness of, or access to, contraception. Over 80% of Ethiopians live in rural areas, where traditional beliefs have a greater influence over prevailing attitudes and practices than governmental policies.

The socio-cultural environment influences maternal and newborn health through community beliefs and practices. Understanding the context of such beliefs and practices is central to developing strategies to ensure positive outcomes for both the mother and infant. This paper describes the issues and practices around breastfeeding health seeking behaviour, and positive practices surrounding care of the newborn.

Methods

In-depth interviews and focus group discussions regarding newborn care practices were conducted with newly delivered mothers, older women, and husbands/fathers with young children, health providers traditional birth attendants (TBAs), religious leaders and elderly influential persons across Ethiopia's 11 regions in early 2005. Data collectors were sourced primarily from the College of Social Sciences at Addis Ababa University, and selected for their qualitative research skills and experience, and regional language abilities. The research sites represented a cross-section of livelihoods, gender roles and status, and disparity in access to health services. Data were gathered from communities in order to obtain a composite picture of community access to, and perceptions of, maternal and neonatal health services.

The experience of over 1000 Ethiopians representing all regions, dominant religions and ethnic groups were obtained. Emphasis was placed on the principles of informed consent, privacy and confidentiality and the researchers explained the objectives of the study, and a guarantee that all contributions would remain anonymous. Participants were encouraged to use local terms and concepts to describe knowledge and practices, and in doing so to construct a picture of the socio-cultural and demographic dynamics that influence maternal and neonatal health, and the care-seeking behavior of the community. (see article in this supplement on 'maternal health challenges' for a more detailed methodology).

Results

Tradition recommends mothers and their newborns to stay at home for 40 days. The principle behind the practice, facilitates the period of rest and repair, establishes breastfeeding and is also justified on the grounds that the mother and newborn are vulnerable to malevolent spirits. Women are not expected to resume their household duties until after this period, but this varies depending on the economic status of the woman and her family and the level of support from her husband.

Some women however have to resume their daily chores soon after birth which varies from around four days to one month. Early commencement of duties can have detrimental health implications such as: delaying full recovery from childbirth, inadequate maternal nutrition and less likelihood of establishing and maintaining breastfeeding: "...their breasts become dry which prevents the baby from getting adequate breast milk and weakens the baby". (Oromiya)

Community perceptions of the causes of peri-natal mortality and newborn morbidity are consistent with those relating to the biomedical causes in the early neonatal period. Stillbirths are believed to be the result of the baby being pressed and crushed in the birth canal during delivery. Immediate causes of birth asphyxia are attributed to prolonged labor or cord strangulation. Indirect causes include an inappropriate workload and inadequate nutrition during pregnancy linked to the mother's sickness, poor access to resources, or perceived negligence during pregnancy.

Religious or spiritual explanations deflect direct blame from the mother or birth attendants, but may reinforce inappropriate practices or responses to morbidity. Many women believe that stillbirths are caused by evil spirits that are out to claim and kill newly born babies. "...some people will leave an unwanted shadow with the baby". (Amhara) Reasons for early newborn deaths are believed to be a result of the way the baby sleeps that leads to

suffocation. Many believe that some babies die after they are born because 'it is the will of the lord' or they may get affected by the strong rays of the sun.

The mother remains the most dependable person to take care of the baby "because she is the one who carried him for 9 months in her womb and understands the pains the child is going through whether the child is ill or not". Women with relative wealth appear more likely to seek care for a sick newborn. However, some women perceive divine purpose to be the overall deciding factor; "...be one rich or poor, it is in Allah's power. (Wealth) does not matter at all.". However others are aware of the signs of a sick infant: an unhealthy baby cries all the time, does not sleep, gets fever, does not breast feed and the eyes may change color to yellow.

Many community members perceive that health facilities are better than traditional healers' ability to treat newborn and infant illnesses. "... My daughter was unconscious when I took her to the health facility. I was thinking she might die on the way. When I got there, they saw the seriousness of her conditions and gave her priority...They healed her... for that, health facilities are very useful..." (Mother, Amhara).

Some mothers in SNNPR believe that if the illness of the baby is related to the 'evil eye', they must go to the traditional healer first. Moreover men's beliefs however may prohibit any care seeking in the early postnatal period: "...and children should not be left alone, because Satan is suspected to take your best child and replaces his bad ones in place. So, a knife is put side by side to the child. Because of this traditional taboo, women are not taken to health facilities" (Oromiya).

Many women and men complained of lack of accessible health care that they could rush to in the case of an emergency. Therefore they have no choice but to rely on traditional medicine as it is easily accessed, readily acceptable. Mothers from Oromiya described the steps they might take if their baby is unwell since there is no health facility nearby: "If the baby gets sick, we'd try traditional medicine, and if the sickness persists, we'd go to a health facility". Another respondent mentioned "In the meantime, we'd give the child traditional medicine until we search for money for the medical expense". However traditional medicine is perceived as very reliable for treating skin diseases; "... For example when babies have rash on their skin, mothers chew a herb and then rub it on the skin swellings and it cures them ...they stop crying..." (Young mother, Amhara)

Findings from Amhara-revealed there are some babies who died at the health facility because there is either lack

of health provider to attend to the baby immediately often due to long queues, lack of the proper equipment or other basic supplies and medications. However older women from Tigray established that the number of newborn deaths is going down due to a health facility nearby and most of the children are taken there for treatment.

Failure by the mothers to go to health facilities unless newborn sickness is serious is attributed to lack of money to buy medicine, coupled with exorbitant levies charged in private clinics.

The community is very supportive of newborn vaccination. Opinion leaders in Tigray apparently propagate messages to encourage mothers to take their newborn for vaccination in health facilities. TBAs, mothers and fathers indicated that health centers offer vaccination services which were significant in the sense that it provides a child with immunity from such ailments as Polio and measles. The mothers on the other hand were non-committal on the exact timing of when to take the babies for immunization with most of them arguing that this timing should be between the first month and six months. Some TBAs said that the baby is often only taken for the first vaccination after 6 weeks and many mothers fail to return for subsequent vaccinations.

The variety of care-options cited by communities reflects perceptions of risk and the availability of resources as well as their self-perceived level of control over morbidity, and several options may be utilized in the course of seeking a cure. The initial response to an illness or complication mirrors the community perception of its cause.

There is widespread recognition of the link between maternal nutrition, adequate breast milk, and neonatal health. Most mothers recognize the importance of breastfeeding and that it gives strength and health to the baby and that the baby should continue feeding for some months. A number of TBAs consider that breast milk is very nutritious and boosts the development of the baby's immune system. Although the benefits of early and exclusive breastfeeding are well known, results show that there are conflicting views both within and across the regions regarding the initiation of breastfeeding. Many newborns are not breastfed immediately after birth and initiation of breastfeeding can be delayed up to three days; in the meantime the infant is given butter and the colostrum discarded. "...It is yellowish clotted, thick, too dirty and unhealthy for the baby" (mother Amhara). "...the mother cleans her breast with boiled water and pumps her breast to remove colostrum the first breast milk because it causes stomachache to the baby ..." (Mother Tigray).

In contrast many TBAs and mothers were emphatic that babies are breastfed immediately after birth, provided the

mother has showered and the baby cleaned and wrapped in warm clothing first. Other mothers said they breastfed their babies within the first hour of birth: "*As soon as the child has come out of the womb, it is washed and wrapped with cloths and given to the mother to breast feed it*" (Oromiya). "*This yellow milk is not discarded because it is believed to be important in that it makes the baby strong ...*" (Untrained TBA from SNNPR). "*..... I advise the mother to give the colostrum to the baby because it is very nutritious...*" (TBA Amhara). "*We used to think that the baby comes out of the womb with his food and that we don't need to give him any for some time, but now she can give him the breast right away.*" (Tigray). Majority of respondents said that babies should be fed frequently; initially every two hours and whenever the babies are hungry and the mother's breasts feel full.

In Muslim communities, as soon as the child is born, holy water is given to the infant. The timing of introduction of other complimentary foods varies from 1-day old to 6-months. Complimentary foods include butter, cow's milk, porridge, tea (made from specific leaves), and glucose water. "*I thought if he swallows butter, his stomach would be full and he would be able to sleep well. I buy fresh butter from the market and give it to him*" (Mother Amhara).

In Amhara frequent exposure of the newly born baby to the morning sunlight is recommended for strengthening of the baby's bones. This exposure was determined to commence when the baby was between 4-days old and or after 40-days and lasted an average of about 5-minutes.

Discussion

The roles of both community and formal health sector are determined by multiple, contextually dependent variables. Women do not seek care due to poverty, distance and limited understanding of the benefits. Conversely communities do attach importance in supporting women during pregnancy, childbirth and postnatal period as evidenced by the many rituals and beliefs described. Often the causes of newborn morbidity are associated with inappropriate antenatal practices and prolonged labor.

The community perceive the postpartum period as a time for the mother to regain her strength and cultivate breast milk, and to bond with the baby. Communities concur in the belief that it should be a period of relative rest for the mother, with a reduction, or absence, of domestic and agricultural tasks. However, the restriction of mobility has negative implications for newborn check-ups and seeking care if the newborn falls sick.

Mothers have overall responsibility for the welfare of the newborn, but are supported - resource allowing - by their husbands and the wider community. Attitudes towards formal health advice and services are positive, but under

normal circumstances service access is considered feasible only if health professionals are mobile or community-based. However care is more likely to be sought for the newborn due to higher perceptions of vulnerability and immediate newborn care practices broadly correspond with biomedical recommendations such as providing warmth, food and cleanliness. A healthy baby is perceived as one who feeds well, is clean and contented.

Lactation places high demands on maternal stores of energy, protein, and other nutrients. These stores need to be established, conserved, and replenished. Virtually all mothers can produce adequate amounts of breast milk. However there are conflicting results regarding the initiation of breastfeeding. Many newborns are not breastfed immediately after birth. Findings from some TBAs and mothers revealed that the babies are first fed on butter following delivery in order to give time for the mother to cleanse her breasts of the first colostrums which is perceived to be dirty and unhealthy for the baby. Nevertheless many women and trained TBAs do recognise the importance of colostrums and do not discard it. There was no difference between the four main regions in this respect but intra regional differences more the norm (4,5,6,7).

Immunization is positively viewed as a preventive measure against disease and the majority of families take their infants to health facilities for this but usually only after the 40 days postnatal period.

Malevolent spirits are frequently cited as causes of neonatal morbidity, and the response will often include a spiritual element. Religious or spiritual figures in the community play a symbolic role in sustaining the health of the community, and consequently cannot be ignored in interventions, to which their support and co-operation will lend validity. Herbal medicines are a widespread response to morbidity, and may be used alone or as a complement to spiritual and/or formal health care options. Herbal medicines are either self-diagnosed and administered, or through a traditional healer or herbalist. Mothers tend to seek facility-based healthcare only if the newborn develops an illness that does not respond to initial 'community treatment'.

Very similar results were also found in Bangladesh, Nepal, Pakistan and Tanzania (8, 9). Interventions to improve newborn care must prioritize postnatal care, and take into account the local socio-cultural situation and barriers to accessing including the financial burden [10]. Newborn health is closely tied to maternal health. Improving it requires interventions that address the complex issues such as maternal empowerment, social

cultural taboos and health system responsiveness (11). The state of the health system is as important as the social context and local practices (12).

The formal health sector needs to explore options and opportunities to 'break down the walls' of the health facilities and encourage formal health providers to extend their activities into the communities and to build relationships - through the media of community based health workers such as the health extension workers and TBAs – but with the community members.

Conclusion

When families do seek care for their newborns, remedies from traditional healers are often preferred to skilled health workers because of cultural and religious beliefs, poor access to health facilities, (including distance and terrain) and financial barriers. The baby has great potential as a channel for interventions – as the baby's health is the prime motivation and justification for behaviour and practices. By encouraging mothers to seek care for the infant, one can also target the mother's health and promote healthy newborn practices.

Acknowledgements

Further to the original Safe Motherhood Community Based Survey Report 2006 funded by UNFPA we acknowledge the support from John Snow Inc and The "Last Ten Kilometers: What it Takes to Improve Health Outcomes in Rural Ethiopia Project" for providing Population Council with the opportunity to reanalyze in depth the findings in four major regions: Tigray, Oromiya, Amhara and Southern Nations, Nationalities And Peoples. We acknowledge the financial support from The Bill and Melinda Gates Foundation for this additional in-depth analysis.

References

1. Lawn J, Cousens S, Zupan J, 4 million deaths: When, where and why? *Lancet* 2005, 365:891-900.
2. Central Statistical Authority (CSA) and ORC Macro. 2000. Ethiopia Demographic and Health Survey. Addis Ababa, Ethiopia.
3. Federal Ministry of Health, Ethiopia, 2006. Final Report on the Safe Motherhood Community-Based Survey, Ethiopia.
4. Warren C, Kebede S. Safe Motherhood Community based Survey: Findings from Amhara Region, Ethiopia. 2009.
5. Warren C, Kivunaga J. Safe Motherhood Community based Survey: Findings from Oromiya Region, Ethiopia. 2009.
6. Warren C, Kivunaga J. Safe Motherhood Community based Survey: Findings from Tigray Region, Ethiopia. 2009.

7. Warren C, Kebede S. Safe Motherhood Community based Survey: Findings from SNNP Region, Ethiopia. 2009.
8. Mrisho M, Schellenberg JA, Mushi AK, Obrist B, Mshinda H, Tanner M, et al .Understanding home-based neonatal care practice in rural southern Tanzania. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 2008; 102(7):669-78.
9. Syed U, Khadka N, Khan A, Wall S Care-seeking practices in South Asia: using formative research to design program interventions to save newborn lives. *Journal of Perinatology*, 2008; 28:S8–S12.
10. Waiswa P, Kemigisa M, Kiguli J, Naikoba S, Pariyo GW, Peterson S Acceptability of evidence-based neonatal care practices in rural Uganda - implications for programming *BMC Pregnancy Childbirth*, 2008 June; 8:21.
11. Bhutta ZA, Darmstad, GL, Hasan BS, Haws RA. Community-based interventions for improving perinatal and neonatal health outcomes in developing countries: A review of the evidence. *Pediatrics* 2005;115(2):519-617.
12. UNICEF. *The State of the World's Children: Maternal and Newborn Health*. 2008.