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Maternal cultural practices for neonates' care in upper Egypt

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ABSTRACT

Problem: Little is known about the home practices and care given to neonates born in Egypt.
Background: Two thirds of all infant deaths in Egypt occur in the neonatal period and many of these deaths occur in the home environment out of sight of health care providers. Understanding cultural practices and beliefs about caring for neonates may help direct appropriate interventions to improve infant outcomes.
Aim: To describe maternal cultural care practices used with neonates and highlight harmful practices in order to identify areas of required change in care.
Methods: A descriptive study using a convenience sample of 200 women recruiting from outpatient pediatric facilities in Qena, Egypt. Face to face interviews were used to gather data.
Findings: More than one third (37.5%) of the studied women given birth in the home, and a traditional birth attendant assisted with the majority of home births (90%). Breast-feeding was delayed between 1 and 4 days in 27% of the women and they were more likely to use cultural practices, rather than modern medical practices, for neonatal eye and umbilical care. Maternal cultural practices used in the home can be categorized as being harmful, beneficial, and as having no-effect on neonatal health based upon available evidence.
Discussion: A variety of cultural practices are used by women for neonatal care in upper Egypt. Many of these practices may have a negative effect on neonatal health and should be discontinued.
Conclusion: Comprehensive interventions are needed to modify women' care practices.

Statement of significance

Problem or issue

The neonatal period is a critical time for both mother and infants. Neonatal care needs are often in conflict with cultural Egyptian infant-care practices.

What is already known?

Infant mortality in the first week of life in Egypt occurs mainly in the home without parents seeking health care.

What this paper adds?

Maternal cultural practices in the home following birth in either a health care setting or the home includes many unsafe practices that can contribute to infant morbidity or mortality including using unclean instruments to cut the umbilical cord, delayed initiation of breastfeeding, and use of homemade remedies for neonatal eye care that are irritating.

Abbreviations: MCH, mother and child health centers; WHO, World Health Organization; TBA, traditional birth attendance; MC, Monte Carlo.

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1. Introduction

Before the twenty-first century, few governmental policies, health care programs, or health care research focused on improving neonatal health in developing countries,[1] leaving neonatal mortality as the most neglected health problem.[2] Worldwide, the neonatal mortality rate is 20 per 1000 births.[3] In Egypt, neonatal mortality (11.8/1000) comprises two thirds of infant mortality (18.6/1000) and half of all mortality in children under 5 years of age (21/1000).[3] Of the 4 million neonates who die annually around the world, the vast majority of them are born in developing countries[1,4] in the home environment.[1,5]

Infection (e.g., tetanus, pneumonia, septicemia and diarrhea) is the leading cause of neonatal mortality.[1] One common neonatal infection in developing countries is omphalitis, an infection originating in the umbilical cord, which is responsible for 520,000 neonatal deaths annually.[6] Omphalitis could be avoided with the cost-effective adoption of application of 7.1% chlorhexidine gluconate to the neonate's umbilical stump daily during the first week of life.[7–9] Other cost-effective neonatal interventions include neonatal resuscitation, early recognition and treatment of infections, skin-to-skin care, and immediate and exclusive breastfeeding to avoid other high cost interventions.[5] Therefore, policy and health care initiatives should focus on strengthening and expanding cost-effective interventions to reduce neonatal mortality.[2] To understand how to best target these initiatives it is important to understand cultural practices which can have an adverse impact on neonatal outcomes.

Cultural practices reflect values and beliefs held by members of a community for periods often spanning generations.[10] Cultural health beliefs also influence whether a family seeks health care or adheres to care providers' treatment plans. Some individuals believe that cultural practices and therapies are more effective than medical prescriptions. However, direct harm to the women and neonate may result from such practices. For example, if unclean instruments are used during childbirth to cut the umbilical cord it could cause an omphalitis. Use of cultural practices may also contribute to delays in seeking medical intervention.[11]

Best health care practices differ across countries and geographical regions; an accepted practice in one country may be unacceptable or high risk in another country.[12,13] For instance, home birth may be high risk in developing countries, while it could be a safe option in developed countries.[13] In fact, home births in the developed countries are associated with better outcome and less morbidity than the hospital birth setting.[14–16] One explanation for poor home birth outcomes in developing countries is the delay in accessing appropriate services during the emergent situations that could address home birth as high-risk.[17,18] In addition, women in the developing countries are already at greater risk for hemodynamic compromise from relatively small amounts of blood loss[18] this makes home births less safe than developed countries. Finally access to health care often requires traveling long distances, making timely care for women and neonates in rural areas difficult and leading to morbidity and mortality with minor problems.[18]

Egypt, despite being one of the largest and strongest economies on the African Continent, is still classified as a developing country.[19] Egypt has two distinct regions with different health services and outcomes. Upper Egypt, in the south, is predominantly rural and historically has had poor health outcomes, while Lower Egypt, in the north, includes the capital city and is more urbanized and affluent.[20] Qena, an area of Upper Egypt, is predominantly a low-income, rural farming area offering its residents limited access to basic health care.[21] While the rural data are not available in Upper Egypt, the urban infant mortality rate is 39 deaths per 1000 births.[22] Upper Egypt also has fewer health care providers, despite a sufficient number of providers in the total Egyptian workforce. Consequently, the majority of neonates in Upper Egypt are born in the home without a health care provider in attendance.

Tinker and Ransom argued that millions of neonatal deaths could be avoided if more resources were invested in the development of low-cost interventions designed to address factors that impact neonatal mortality.[23–25] Despite the importance of care practices in the neonatal period, little information exists about routine neonatal home care practices or how these practices may affect neonatal outcomes.[26] Only one study conducted in Egypt has explored the sources of information that women rely on for care of the neonate at home.[4] These authors found that mother's mother and the traditional birth attendant (TBA) or daya worked together as consultants to the women to provide necessary care information, however information about mothers' specific care practices provided to her neonates at home and who influenced that care is unclear. Understanding current cultural practices may help us develop new, or direct existing appropriate interventions to improve the health of infants. Moreover, to decrease neonatal mortality, health care providers needs to understand the local beliefs about, and behaviors related to the home care of neonates.[2,27]

2. Methods

2.1. Study aim

Our study aim was to describe maternal cultural practices for neonatal care and highlight practices that may have a negative effect on neonatal health.

2.2. Research question

What are the practices used by women in the care of their neonates' in Upper Egypt?

2.3. Study design

A descriptive exploratory design allowed for an in-depth understanding of typical cultural practices used to care for neonates. The Ethical Committee of Nursing Collage in Alexandria University Egypt approved the study. Women provided ethical fully informed and free consent prior to the structured interview with the first author.

2.4. Setting and participants

Four maternal and child health centers (MCHs) Sedi Abdelrehim, El-Gebil, Awlad Amar, and Dandarah plus an outpatient clinic of South Valley University Hospital in Qena City were used to recruit women during a clinic/center visit for their infants' vaccinations between August and December of 2011. Women were eligible for study participation if they had vaginal and uncomplicated birth (without congenital anomalies), full-term infant who was no more than two months of age at the time of the interview. This time frame was felt to facilitate more accurate recall of information.

2.5. Measure

The structured interview tool was developed by researchers based on relevant literature and local culture to elicit information about cultural maternal practices in the care of their neonates. The structured interview tool contained two parts: Part 1: The Socio-economic Characteristics of the Family, contained introductory questions about the family such as maternal data (age, level of education, and occupation), paternal data (age, level of education,

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