International Journal of Medical Science and Clinical Research Studies

ISSN(print): 2767-8326, ISSN(online): 2767-8342

Volume 03 Issue 07 July 2023

Page No: 1417-1422

DOI: https://doi.org/10.47191/ijmscrs/v3-i7-34, Impact Factor: 6.597

Cleanliness is Next to Holiness: Personal Hygiene Practices among Child Bearing Mothers in Ekiti State, Nigeria

Serifat Asabi Babalola[1], Ifedayo Charles Ajewole[2]

[1]Department of Community Medicine, Afe Babalola University (ABUAD), Ado-Ekiti, Nigeria.

[2]Department of Community Medicine, Ekiti State University Teaching Hospital (EKSUTH), Ado-Ekiti, Nigeria.

ABSTRACT

Safe motherhood can be defined as efforts towards protecting and promoting the healthy life of the women and that of the babies through pre – conception, antenatal, intrapartum and postpartum care. It ensures perfect quality of life for women of reproductive age group through medical and non- medical services. The study is a cross sectional, descriptive study carried out among One hundred and eighty (180) mothers in selected communities. Selection was done using simple random sampling technique in the three senatorial districts in Ekiti State. Ethical certificate of clearance and informed consents were obtained for the study. Data were collected using structured questionnaire and analyzed with SPSS version 20 The study shows that safe motherhood knowledge was adequate(77.9) among the respondents. This is really expected because majority (77.2%) of the mothers are well educated. The study shows that majority (92.5%) has good personal hygiene practice. Safe motherhood services must always be accessible in all health care institution to sustain and improve on the knowledge level and good hygiene practices.

KEYWORDS: knowledge, practices, safe motherhood, personal hygiene.

ARTICLE DETAILS

Published On:
26 July 2023

Available on:
https://ijmscr.org/

INTRODUCTION

Safe motherhood refers to situation in which a woman went through the physiological processes of reproduction without any adverse outcome to the mother and that of the baby (Action Health, 1999). According to World Health Organization – WHO (2000), Safe motherhood is a global initiative aiming at reducing maternal morbidity, mortality, infant morbidity and mortality. Similarly, Partnership for Transforming Health Care System – PATHS (2005) define it as combination activities by a pregnant woman, family members, community and all health care providers to ensure safety of a pregnant woman and that of her baby throughout the stages of conception, delivery and child birth.

The scheme is achieved through combination of programs including family planning services and safe abortions (where permitted); prenatal, antenatal, delivery and postnatal care at the community level and referral services for complication. It also include promotion of breastfeeding, immunisation and nutrition services (Daly, Azefor, Nasah, 1993).

Mahler (2002) stated that safe motherhood is achieved through multiple interventions to reduce maternal mortality and also improve the reproductive health status of women. According to Adesokan (2010) safe motherhood comprises of all efforts to reduce deaths and disabilities resulting from reproduction 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 maintain the healthy life of the mother and that of the baby. (Surat, 2002)

Nigeria is the largest country in Africa with a population of over 160 million people and about 31 million women of childbearing age (Abimbola, Okoli, Olubajo, Abdullahi & Pate, 2012). Maternal mortality is estimated to be 828 deaths per 100,000 live births in the rural areas and 351 deaths per 100,000 live births the urban areas ((Abimbola, Okoli, Olubajo, Abdullahi & Pate, 2012). Regional variations in maternal mortality figures across Nigeria has also be noted, maternal mortality rates (MMR) are significantly higher in northern Nigeria. (Abimbola, Okoli, Olubajo, Abdullahi & Pate, 2012; Adegoke, Lawoyin, Ogundeji & Thomson, 2007).

Statement of problem

An estimated half a million maternal deaths that occur each year in developing countries, Nigeria inclusive. (Hogan, Foreman, Naghavi, Ahn, Wang, Makela, Lopez, Lozano & Murray, 2010). A review of the Millennium Development

Goals (MDGs) reported that limited progress has been made to reduce maternal mortality especially across developing countries including Nigeria (Abimbola, Okoli, Olubajo, Abdullahi & Pate, 2012). However, several community-based approaches to improving maternal health outcomes are still evolving.

Most developed countries have made remarkable progress in addressing maternal mortality, but it appears that countries with high maternal morbidity and mortality burdens like Nigeria and in particular Ekiti state have made little or no progress in improving maternal health outcomes despite emphasis by the MDGs. Knowledge about safe motherhood initiatives could help reduce pregnancy related health risks and improve maternal outcomes.

Justification of the study

Female gender, especially women of child bearing age (15-49 yrs) should be the important target in any government's policy formulation. Safe Motherhood Initiatives (SMI) clearly stated that maintenances of adequate health particularly of infants, children and mother is critical to attainment of optimum maternal health and national development (WHO 1999). Studying the women of child bearing age in relation to reproductive process, action and health cannot be over emphasized.

This study aimed at determine the knowledge level of various components of SMI.

Specific Objective:

1. Determine the level of knowledge of various components of SMI among the respondents.
2. Ascertain hygiene practices among the respondents..

RESEARCH METHODOLODY

Ekiti state is one of the Yoruba state. It has sixteen (16) local governments with three senatorial districts. Total area is 6,353 square km (2,453sq miles). (Oguntuyi, 2005). The study was carried out among women of reproductive age in the selected settlements within. Ekiti state.

SAMPLING TECHNIQUE AND SAMPLE SIZE DETERMINATION

Formula for sample size.

$N = \frac{P(1-P)Z^2}{D^2}$ where Z-1.96, D- 0.05

P – Percentage of maternal mortality due to poor antenatal care =15% according to National Health Demography (2008).

P =15% = 0.15

$N = \frac{0.15(1-0.15)1.96^2}{0.05^2}$

$N = \frac{0.432718}{0.0025}$

N= 172.872

N = 180

Source: Armitage and Berry (2009)

SAMPLE TECHNIQUE AND SUBJECT SELECTION.

Multistage sampling method was used. Ekiti North senatorial district was selected by randomly by balloting. Three Public Health Institutions were selected by simple random technique from the list of health facilities in the district. All Women of child bearing age 20 -45 years attending clinics in Ekiti state hospitals were included in the study while women that are seriously ill were excluded from the study. Data was collected for the study using a structured questionnaire which the respondents filled. A total of one hundred and eighty (180) structured questionnaires were administered to the respondents. Data was analyzed with social science statistical packages (SPSS) version 20. Ethical certificate of clearance was obtained from the Ethics and Research committee of national Open University. Participation was voluntary, informed consent was obtained, confidentiality was maintained and the study was beneficence and no harm to the participant. There was no Conflict of interest.

RESULTS

Table 1: Socio-Demographic Data Age

AGE	Frequency N=163	Percentage =100
19 – 25 years	30	19.1
26 – 30 years	25	15.9
31 – 40 years	**78**	**49.7**
Above 40 years	24	15.3
MARITAL STATUS		
Never married	16	9.8
Married	**135**	**82.8**
Separated	5	3.1
Widow	5	3.1
Divorced	2	1.2
EDUCATIONAL LEVEL		
None	4	2.5
Primary	4	2.5

Secondary	40	24.5
NCE/OND	37	22.7
HND/B.Sc.	**64**	**39.3**
Postgraduate	14	8.6
OCCUPATION		
No response	2	1.2
Accountant	4	2.5
Cleaner	3	1.8
Civil servant	43	26.4
Doctor	2	1.2
Health Attendant	10	6.1
House wife	2	1.2
Nurse	39	23.9
Student	18	11.0
Teacher	20	12.3
Trader	20	12.3

The table above shows that about half 78(49.7%) falls within 31-40years of age, 135 (82.8%) were married, very few 4(2.5%) of the respondent had no formal education, 124 (76.1%) of the respondents are Christians, while 39 (23.9%) are Muslims.

Table 2: Respondents knowledge of Safe Motherhood initiatives components.

SN	Knowledge	Freq	%
1	Number of recommended Antenatal care (ANC) visits	132	81.0
2	Benefits of ANC visits	148	90.8
3	Diseases preventable by medications given during ANC visits	111	68.1
4	Maternal danger signs	113	69.3
5	Actions in safe pregnancy plan	109	66.9
6	Benefits of health facility delivery by skilled birth attendants	125	76.7
7	Knowledge of clean delivery practices	145	89.0
	Average		**77.9**

The table 2 above reveals that the knowledge of safe motherhood components among Child Bearing Mothers (CBMs) was considered adequate (77.9%). Further, all items among knowledge of safe motherhood practices met the 50 per cent cut off as recommended by World Health Organization international standard.

Table 3: Personal hygiene knowledge and practices among respondents

SN	Personal hygiene knowledge and practices	Freq	%
1	Cleaning the breast with salt tepid water solution before breast feeding	113	69.3
2	Proper cleaning and hygiene of the environment	163	100
3	Washing of vegetables, fruits and other food items before consumption	159	97.5
4	Washing of hands with soap and water after using the toilet	161	98.8
5	Bathing twice daily	135	82.8
6	Covering of cooked food against rodents and vectors	161	98.8
7	Use of safe and clean water	163	100
	Average		**92.5**

Table 3 above shows that the personal hygiene knowledge practices of CBMs was excellently adequate (92.5%)

DISCUSSION

The knowledge of safe motherhood practices (77.9%) were adequate among CBMs in Ekiti state. This is really expected because majority of the mothers are well educated, they value the importance of knowledge of safe motherhood practices. This finding is line with UNICEF (2004) which stated that adequate knowledge of safe motherhood practices during pregnancy and after delivery would save millions of life yearly. Obionu (2006) agreed that knowledge of safe

motherhood practices is really the most cost effective means of preventing some of the adverse outcomes of pregnancy

The study revealed that majority of the respondents have an amazing result (92.5%) concerning the personal hygiene practice. This is supported by Surat (2002) who reported that 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. Similar study by Lawoyin (2008), also reported similar finding.. This shows that mothers now appreciate the importance of personal hygiene as a preventable tool in health education. The findings were equally in agreement with findings by Babafemi (2002) who stated that despite the every other challenges, women still have skills for positive personal hygiene practices

Based on this finding, adequate knowledge of safe motherhood and personal hygiene practices were optimal among the study population.

The following recommendations are necessary:

1. Health institutions and health care professionals should design better educational strategies to maintain and improve knowledge on prevailing health issues among women of reproductive age.
2. Government should made policy to coordinate and fund research on sustainable practice of safe motherhood.

REFERENCES

I. Abimbola, S, Okoli, U, Olubajo., O, Abdullahi M. J, Pate M. A (2012): The Midwives Service Scheme in Nigeria. PLoS Med 2012, 9(5):e1001211.
II. Acharya, L. B. (1998). "Effect of Mobile Health Workers on BCG Vaccination in Rural Areas of Western and Mid-western hill Districts of Nepal", Population and Environment, Vol. 1 (Kathmandu: MOPE), pp. 1:88-89.
III. Adegoke, A. A., Lawoyin T. O., Ogundeji M. O, Thomson A. M. (2007): A community based investigation of avoidable factors of maternal mortality in Nigeria: the pilot experience. *Afr Health Sci*. 2007, 7(3):176–181.
IV. Adesokan, F.O.D (2010). Reproductive health for all ages: Ekiti State: Sammy prints.
V. Adeyemi, T. S. (2004). *Report on mapping of EOC facilities in Nigeria,* UNICEF, Lagos.
VI. Ajurved, O. E. (2000). *Study on the right to health in Nigeria* Lagos: Shelter Right Initiative Organization.
VII. Awosika, O. D. (2001). The ominous Nigeria health care system: Is there hope for solution?
VIII. Babafemi, J. O. (2002). Food taboos in maternal and child health. *Journal of Maternal and Child Health, 28,* (9), 12 – 26
IX. Bello, G. F., Hassen, M., Shehu, D, & Andu, I. (1997). Community education to encourage use of emergency obstetric services in Kebbi State, Nigeria. *International Journal of Gynecology and Obstetrics* 59. 5191-5200.
X. Cohen, L; Manion, L & Morriron, K (2011). Research methods in education. United Kingdom: Rutledge..
XI. Elder J, Ayala G, Harris S (1999): Theories and intervention approaches to health-behavior change in primary care. *Am J Prev Med*, 17:275–284.
XII. Gay, L.R (1981). *Education research: Competency for analysis and application* (4th ed) Columbus: Merrill.
XIII. Harrison, K.A. (1997): The importance of the educated healthy woman in Africa. *Lancet*, 349:644–647..
XIV. Jatau, A.A. (2000). Strategies for promoting safe motherhood in Nigeria by the 2010. *Nigeria Journal of Health Education*, 9, 282-294.
XV. Langer, A. Farnot, U., Garaa, C., Barros, F., Victoria, C., Belizen, J.M., & Villaar, J. (1996). The Latin American Trial of psychosocial support during pregnancy: Effects on mother's well being and satisfaction. *Social Science and Medicines,* 42, 1589-1597.
XVI. Lawoyin, T. (2008). Risk factors for maternal mortality. *Nigerian Medical Journal, 32* (1), 4 – 18.
XVII. Mushi, D., Mpembeni, R., & Jahn, A. (2007): Knowledge about safe motherhood and HIV/AIDS among school pupils in a rural area in Tanzania. *BMC Pregnancy Childbirth*, 7:5.
XVIII. National Population Commission, (NPC), (2009) ICF Macro: Nigeria demographic and health survey 2008. Abuja, Nigeria: National Population Commission and ICF Macro; 2008.
XIX. Nigerian Partnership for Safe Motherhood, (2003). *Training Curriculum for Leadership in safe motherhood initiative*. Ibadan: University Press Ibadan.
XX. Obionu, C. N. (2006). *Primary health care for developing countries.* Enugu: Delta publishers Ltd.
XXI. PATHS (2005). Maternal and child health. *Journal of World Health Forum, 7* (21), 11 –21.
XXII. .Roth, D. M. & Mbizvo, M. T. (2001): Promoting safe motherhood in the community: the case for strategies that include men. *Afr J Reprod Health*, 5(2):10–21.
XXIII. Sharma, M. (2012): Knowledge, attitude and belief of pregnant women towards safe motherhood in a rural Indian setting. Social Sciences Directory 2012, 1:1.
XXIV. Surat, L. L. (2002). Dead mothers and injured wives: the social context of maternal morbidity among Hausas of northern Nigeria studies on family planning. *Journal of Family Planning, 29* (4), 7 – 9.

XXV. UNICEF (2003). *Obstacles to, and intervention for maternal mortality reduction in health.* UNICEF, Lagos.

XXVI. UNICEF (2003). *Safe motherhood and child health care services.* Geneva:

XXVII. UNICEF (2004). *Girls and women: A UNICEF development priority.* UNICEF, New York.

XXVIII. WHO, (2005). New Approach to save lives of Mothers and Children, (WHO, Report, 2005).

XXIX. WHO, (2000). *Strategies for promoting safe motherhood in Nigeria by the year 2010.*