ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 7| Issue: 11| November 2021|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2021: 8.047 || ISI Value: 1.188

ETHNOMEDICAL PERCEPTIONS OF PREGNANCY THREATS AND HOMEBIRTH PREFERENCE IN RURAL CAMEROON: THE CASE OF NCHANG, SOUTH WEST REGION

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Article DOI: https://doi.org/10.36713/epra8923
DOI No: 10.36713/epra8923

ABSTRACT

The principal objective of this research has been to highlight ethnomedical understanding of risk factors causing mishaps in childbirth as the fundamental determinant to low facility-based deliveries. Skilled obstetric assistance has been proven to significantly reduce maternal morbidity and mortality. Reliance on facility-based delivery is therefore fundamental to maternal wellbeing. However, preference for homebirth is still common and prevalent in rural Cameroon where socio-cultural perceptions still exert strong influence on health-seeking decisions and behaviors. Understanding the reasons for this preference is important to design targeted interventions for more effective maternal death control schemes. This qualitative research was carried out in all ten quarters of Nchang using both random and snowball sampling techniques to select participants. Forty in-depth interviews and four focus group discussions were conducted using corresponding research tools. Verbatim translation and transcription of audio recordings was done from pidgin or kenyang to English, followed by codification and a thematic analysis. Our findings reveal that low demand for obstetric assistance and its consequential correspondingly higher maternal mortality rates are fundamentally determined by socio-cultural perceptions of pregnancy threats.

KEYWORDS: ***perceptions, facility-based delivery, obstetric assistance, homebirth, maternal mortality,***

INTRODUCTION

The understandable diversity of human cultures notwithstanding, compliance to the natural principle of species reproduction is a common behaviour in every society. As a strong indication of the fundamental importance of childbirth, especially in perpetuating group existence, values and identity, every human group has established well defined norms governing behaviours for safe delivery outcomes to both mother and child. Clinically, according to the World Health Organisation [1], the norm for safe delivery is adequate antenatal care and obstetric assistance. It gives room for expectant women to be given important information, be screened of related risks and be treated promptly or appropriate referrals [2, 3]. These notwithstanding, childbirth is not always hitch-free given the recurrent death of women who battle in vain for their lives while struggling to give life. In fact, 467 deaths per 100,000 live- births were recorded in Cameroon in 2018 [4]. Traditional societies are most hit by this, raising logical preoccupations on not just the role of inadequate maternal healthcare but more so the influence of the usually dominant ethnomedical perspectives and therapies. In actual fact, this influence is most apparent with disparities in maternal death rates amongst women from two culturally dissimilar groups exposed to similar levels of obstetric healthcare. In most rural settings of Cameroon, the apparent imbalance between accessibility of traditional healthcare and insufficiency

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of appropriate conventional health facilities and services offers limited therapeutic choices. Even where medical plurality is a reality, it does not necessarily translate to balanced polarisation of patients' demands for every sector in the local health system. Apart from unavailability, utilisation of antenatal care and delivery services are influenced by a web of cultural, social, economic, educational and political factors [5, 6, 7]. Hence, expectant women are often entrusted into the hands of Traditional Birth Attendants (TBA) and other actors in the traditional healthcare subsystem with alleged mastery of appropriate delivery techniques often deeply rooted in their cosmogonic discernments [8, 9, 10]. (Non)adherence to these practices fundamentally determine delivery outcomes given that some facilitate successful childbirth while others increase vulnerability to obstetric complications, morbidity and death. Most of the known biomedical causes of maternal deaths including anaemia, obstructed labour, infections, haemorrhage, unsafe abortion, and hypertensive disorder [11, 12], are often subjected to ethnomedical interpretations. Such interpretations generally neither correspond to clinical realities nor reflect the full nature of their biomedical risks.

THE STUDY CONTEXT

Nchang is a village located about six kilometres from Mamfe, the sub-divisional headquarters of Manyu division, South West Region of Cameroon. It is situated along the Mamfe-Ekok road and together with two other villages; Egbekaw and Bachuo-ntai, form the Kenyang speaking Nfortek clan of the Bayang ethnic group. The village is surrounded by a host of other Kenyang speaking villages like Besongabang, Ntenako, Nfuni, Ebam, Eyang-nchang, Agborkem, and Egbekaw. Fundamental to the world view of the Bayang ethnicity is the perspective that man's world is both physical and cosmic. Both spheres continuously interact with and auto influence each other for an optimal state of harmony. Health and wellbeing are said to be possible only through maintenance of this harmony meanwhile disease, death and other misfortunes are believed to stem from its disequilibrium. Furthermore, the society's perception of the ultimate finality of a woman's existence is motherhood. This is possibly a reflection of one of the society's fundamental perceptions of babies as a sure bridge through which good fortunes are tapped from the supernatural ancestral realm and brought into the physical realm. A woman's status within the family and society is principally determined by the number of children borne and catered for. In order words, her reward is a measure of the number of times she has offered the community with the possibility for good fortunes to be brought into the lives of her family members and friends. As such, from childhood to maturity, she is prepared to appropriately execute this task through strict respect for particular local customs and traditions. Most of these practices and cultural imperatives apparently emphasize family or group interests even above those of mothers [13]. They shape perceptions of personal health and available health services [14, 15] and therefore influence health-seeking. It is therefore understandable that women are most unlikely to make individual reproductive decisions that are contrary to those of her husband and the community at large.

It is believed that the belief in and practice of other alien customs contrary to or different from these mainstream traditions are usually not to the interest of the group. They often lead to cultural noncompliance especially amongst younger women. This directly triggers the earlier mentioned disequilibrium between the physical and cosmic worlds sanctioned by the occurrence of a wide range of misfortunes, most of which are closely related to childbirth. Hence, obstetric complications and maternal mortality are nothing but the consequences for transgressing socio-cultural norms meant to maintain the desired harmony between the visible and invisible worlds. However, such misfortunes can equally be an unfortunate way through which the fault of an ascendant is expiated. It can also result from a malevolent attack by a supernatural being, influenced and manipulated by a fellow community member for personal and often egoistic purposes. Either ways, maternal death is generally the consequence of a personalistic manoeuvre frequently qualified as irrational and inconsequential from the biomedical standpoint.

In addition to childbirth, women play dominant roles in enculturation and subsistence agriculture; understandably the mainstay for livelihood within this farming community. The family in particular and society in general suffer a huge blow each time a woman dies given the far reaching consequences on social welfare and stability. Hence, the raison d'être of this research tailored to highlight the influence of ethnomedical perspectives on homebirth preferences given the reliance of large proportion of women on traditional birth attendants.

MATERIALS AND METHODS

The qualitative and exploratory research approaches were used. The study was cross-sectional employing qualitative method of data collection to examine the influence of traditional patterns on health

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behaviors directly or indirectly related to maternal vulnerability towards morbidity and mortality. These patterns included pregnancy and childbirth related taboos, prescriptions from Traditional Birth Attendants, herbalists and other related tradipractitioners frequently solicited within the local health sub-system. Nchang was deliberately chosen amongst the other villages constituting the Nfortek clan of the Bayang ethnicity, given its significant distance from the increasingly cosmopolitan and multicultural nature of Mamfe town with its consequential influence on local customs and traditions. Hence, access to eligible participants predominantly reliant on traditional delivery methods was relatively easier. Through documentary research, a good number of published and unpublished essential secondary data were collected, most of which revealed that substantial reduction of maternal mortality, especially in rural areas, can only be achieved through significantly increasing available and accessible quality biomedical facilities and services.

However, not much is reportedly done to highlight and understand how ethnomedical perceptions shape health-seeking decisions and behaviours. Thus fieldwork was done enabling collection of primary data. Our research sample was constructed on the bases of certain socio-demographic variables like ethnicity, number of children, age, sex, religion, occupation, level of education. Custodians of tradition, tradipractitioners especially TBAs, doctors and nurses at the local health centre, expectant and nursing mothers, friends and relatives of a deceased resulting from childbirth were thus prioritised.The tools for data collection were pre-tested in Bachuou Ntai village; presenting similar socio-cultural characteristics, in order to determine pertinence of questions with respect to their ability to trigger responses required to meet assigned objectives. Two sampling techniques were used: random sampling during which informants were profiled and selected as we randomly moved around the ten quarters of Nchang; and snowball sampling, during which we were directed to more resourceful persons.The assistance of a cultural aid was solicited now and then for in-depth understanding. Triangulation for verification of data reliability was ensured through the use of three traditional anthropological research techniques. To begin with, in-depth interview was administered to forty respondents enabling probing into responses for maximum collection of knowledge, opinions and experiences.

At the convenience of the respondent, Pidgin English or Kenyang; spoken and understood by almost everybody, was used. To verify the consistency of responses collected through one-on-one interrogations, four Focus Group Discussions were carried out, during which spontaneous and general information was recorded as participants (assembled with assistance from the regent chief) conversed with each other on guided themes. The latter included prevailing socio-cultural norms and practices related to maternal morbidity and mortality and how these influence decisions on maternal health. Direct observation of behaviors and occurrences thought to have a bearing on our research purposes was employed with a minimal interaction to maintain authenticity of information.

ETHICAL CONSIDERATIONS

The research protocol was validated and authorization for fieldwork granted by the Department of Anthropology, in the University of Yaoundé 1, under whose canopy the research was carried out. Every potential participant was informed as fully as possible about the nature and purpose of the research, the procedures to be used, the benefits and possible disadvantage. Informed consent was requested and obtained preliminarily while assurance of confidentiality was built on anonymity of identity. Participants were given the opportunity to decide at their convenience, the place and time of encounter. We gave room for questions to make sure they fully understood what was expected of them. They were also notified on the right to answer or avoid certain questions and even to withdraw from the study at any time without being penalized. Equally, informants were informed of where and how the research findings could be accessed should they wish to know it.

DATA PROCESSING AND ANALYSIS

Verbatim translation and transcription of audio recordings obtained during the abovementioned research techniques were done from the local Kenyang dialect or widely spoken pidgin to English. However, some key cultural expressions were maintained in kenyang, given that we could not find suitable translation in the English language having the same meaning. After ensuring that the transcripts faithfully reflect the recordings, Microsoft word files were created and used for their storage together with associated field notes. Data driven codification was employed enabling designation of particular codes to certain parts or categories of our data having similar meaning. This was facilitated by the color reference technique consisting of applying the same coloration to similar responses from different respondents to the same question. Patterns and consequently themes were derived from this data interconnectivity. Quotations from respondents, highly representative of each theme

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vis-à-vis their stance on the relationship between traditional patterns and maternal health, were selected from the transcripts to be added on the written texts for easy comprehension. Based on these, we established an interpretative approach centered on a few techniques of analyses such as the narrative analysis which looks at the beliefs, customs, values and social contexts of when, how and why the sequence of events unfolded. This technique of analysis also enabled us to highlight repeated similarities stemming from different accounts by informants on the same subject. We equally made use of the grounded theory analysis which enabled us to connect emerged categories and concepts with certain theories for generation of meanings. These permitted us to bring out trends that are specifically oriented towards answering our research questions and attaining our research objectives.

RESULTS AND DISCUSSION

Man has designed various institutions and webs of customs that regulate and order his social life. However, unlike some institutions such as the family, kinship, economic and political institutions, religion encompasses wider designs of the universe, the forces that govern it and man's place in it. It also includes fundamental principles about the ways in which things and events are interrelated. In this light, every phenomenon that occurs in the society is perceived in a way that reflects the belief system of the people. It is based on these interpretations that measures thought to be appropriate are put in place to either prevent unwanted experiences or minimise their effects. Although a few causes of maternal mortality are attributed naturalistic origins, a large majority of them are thought to result from the intentional influence of a physical or spiritual entity as shall be seen. This could take many forms; an attack, response to attack, or the repercussion from a transgression. Most, if not all of these do not correspond to the clinical understanding of the causes of maternal morbidity and mortality. Skilled birth attendants in the local health centre neither believe nor take into consideration such ethnomedical correlations. Consequently, homebirths are the frequently sought after method for safe delivery in this community given their holistic tendencies that integrate both socio-cosmic and biological approaches. The following ethnomedical perceptions relating to maternal mortality significantly highlight the fundamental influence of the local socio-culture on preference for homebirths in Nchang:

Infidelity during pregnancy

Like in the other Bayang communities, infidelity of married women constitutes a serious offence within Nchang. It usually results to social sanctions like refunding of bride price and stigmatisation. However, the sanction takes a different dimension when it occurs during pregnancy. In addition to these usual sanctions, a cheating wife during pregnancy is not expected to survive childbirth. The sanction is humanly imposed but ancestrally executed. The bridge usually established by new-borns between humans and ancestors is believed to be destroyed by this single act. Whatever good fortunes were reserved for the community are equally destroyed. Whether she is caught or not her death is believed to be inevitable. This usually takes effect during delivery, a time when the unborn baby can pose serious life threatening difficulties to the mother. It is believed that the child is aware of the fact that he might either die with the mother during delivery or live a very difficult childhood after the mother's death. Coupled with the fact that he has been desecrated by the mother's unfaithful act, he develops hatred for her. He makes all necessary efforts to expose the said evil.

A breeched posture during labour is perceived as deliberate. This can happen even when the expectant mother strictly respects other delivery recommendations. As such, the socio-cultural discernment of breech delivery highlights a common repercussion of transgressing sexual norms during pregnancy. However, it is believed that traditional birth attendants are capable of saving the situation. A particular condition is to be fulfilled for the attendant to move the baby into a head-first posture for delivery to be successful. The mother must admit and confess her immorality. If the woman insists on her innocence and refuses to confess, it is believed that not even the strongest witchdoctor can stop her from dying. To be sure of the paternity of their children, men are said to prefer traditional delivery. The disbelief of healthcare providers in conventional facilities, vis-à-vis such ethnomedical standpoints on maternal mortality fundamentally affects the community's therapeutic choices. The underutilisation of the local health centre for delivery is a clear reflection.

The death of a woman's totem

Generally, totemism is associated to the belief that a family or group of people consider themselves as descendants of a particular animate or inanimate object[16]. However, amongst the Bayangs in Nchang, the concept is pushed further to include personal animate totems. Though living in places far away from human habitation and activities, these totems are

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believed to be spiritually bonded with their human pairs. Once bonded, be it at birth or maturity, their activities auto-affect each other. The death of one automatically leads to the death of the other. Believed to be endowed with supernatural powers, a totem is said to provide protection against accidents or evil attacks. They are equally capable of providing effective preventive or therapeutic assistance against illnesses. On the basis of their good and extensive knowledge of plants with therapeutic values, they administer treatment by consuming it themselves. The villagers affirm that this explains why people get relieved from or healed of some illnesses without employing any particular therapeutic solution. In this light, a woman is believed to be supported by her totem throughout pregnancy making her to be in good conditions for delivery.

However, maternal death from owning a totem is believed to result from three ways; two of which could as well be fatal to anyone with such totemic bond. First and foremost, as earlier mentioned, the death of a totem leads to an inevitable death of its human pair and vice versa. There is no known remedy for this phenomenon. Consequently, the death of some expectant women and community members is believed to result from the death of their totems. Being physical creatures like any other, despite their supernatural capabilities, they can however be killed by hunters. Secondly, death is said to occur when an individual physically beholds his totem or vice-versa. Seeing a wild animal in the forest may appear normal and harmless to any individual given that one cannot tell which particular animal is a totem. Some of the signs and symptoms said to result from this encounter include; loss of memory, swollen body and or loss of speech. The person's health deteriorates continually and if the appropriate rite is not performed on time, death will be inevitable. Many deaths have thus been connected to this.

Thirdly and perhaps most fundamental to the community's preference for the services of traditional birth attendants is the belief that an unborn child and her expectant mother can have different totems. The totemic struggle for dominance between the two animals often results to incompatibility and frequent conflicts. This is believed to be the cause of recurrent illnesses experienced during pregnancy given the upheld vulnerability of expectant women. As such, the latter's health can deteriorate rapidly to dangerous levels if care is not taken. Rites to harness both totemic powers, especially during the early stage of pregnancy, is said to be imperative for the mother's survival. Carried out in the form of ritual bathing and enemas, these rites harness and transform both powers into a sort of powerful maternal immunity. Hospitals neither have the ability to perform such rites nor the will to recommend them. As such, many consider hospital delivery as risky while traditional delivery appears to be the solution.

Inherited curse

The concept of inheritance amongst the Bayangs is vast and complex in its involvement of those concerned. Ownership of most material properties of deceased community members is given to close family members in strict respect of related traditional regulations. In the same light, they can equally inherit the un-expiated ancestral punishments of the deceased. As a matter of fact, the sanctions of certain transgressions are thought to be suffered only by the descendants or close relatives of defaulters even after their death. The nature of the transgression determines the gravity of the punishment. Transgressions of some taboos, like murder or unauthorised harvest from the farm of another, may require the spilling of blood or loss of life for appeasement to be achieved. The consequences of these offences take effect whether the defaulters are caught in the act or not. In this light, one of the most frequently attributed causes of maternal deaths in Nchang is believed to be the punishment of a transgressed taboo by a relative.

In this light, some maternal deaths are perceived as a sacrificial obligation required for expiating a family transgression. This pronouncement is usually made by a traditional priest, given his singular ability to perceive and interpret occurrences with such spiritual depths. Maternal death with no apparent cause, like any other death, often requires the assistance of a village priest for clarifications. Being an intermediary between the ancestors and the living, any required information is revealed to him. Revelations of the exact offence, who committed it and what needs to be done to prevent other relatives from experiencing similar fates, are made known to him. This is supported by the following testimony from a 70 year old male respondent:

> *The ancestors are in total control of the land and are aware of every single happening in the village, whether done secretly or in public. For a long time in our family, women often had difficult deliveries and maternal death was frequent. This was placed in the family by the ancestors because of an offence committed by my grandfather. He had a dispute with a woman who accused him of encroaching into her farmland. She fell terribly and died after being pushed by my grandpa in an attempt to get her out of the way. She always tried to block him*

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from entering the farm. He came back home and told no one about what happened. During her burial, it was revealed that she was pregnant and a curse was placed on the family of the one responsible since nobody came up for the appeasement demanded by the village priest. The curse was removed only after my father came of age and performed all the necessary cleansing rites.

Large foetus

An expectant mother's feeding condition during pregnancy constitutes an important indicator for good health and safe delivery. As such, one of the socio-cultural recommendations for safe delivery is the demand for pregnant women to eat not only in greater quantity than usual but also in greater quality. Apart from making the unborn baby grow healthy and strong, good feeding is believed to provide mothers with the necessary energy to push during delivery and be resistant against adverse natural elements. However, this practice also causes unborn babies to grow bulkier than usual. Their passage through the birth tract is thought to be more difficult. As such, this recommendation is directed only to women with at least one delivery experience. It isbelieved that, following their first delivery, their birth tracts are large enough to contain the passage of bulkier babies.In this light, women on their first pregnancy experience are cautioned to increase just the quality of feeding and not the quantity. With this, babies are controlled from becoming too big.

In this light, an accusing finger is pointed at the tight delivery tracts of some women as the major cause of their death during delivery. Unlike other causes attributed to maternal mortality, a large foetal size is usually attributed to deaths of women during first delivery attempts. This is particularly problematic given the high frequency of teenage marriages in the village. Many women start giving birth at relatively younger ages. Most of these young women are said to lack self-control especially with respect to dietary restrictions during pregnancy. They exhibit little control over their increased urge at this time to eat more causing their babies to be very large. Furthermore, foodstuffs traditionally prohibited on the basis of their attributed fattening potentials to unborn children, are reportedly recommended during antenatal visits in conventional health facilities. Exhaustion, vagina tearing and excessive bleeding amongst others are some of the reported causes of death from large foetuses when hospital dietary recommendations are respected.

Poor patient-healer relationship during hospital delivery

Positive appreciation of doctor and nurse skills and quality of techniques should normally motivate large scale utilisation of hospital services [17,18].However, apart from relatively low cost, the villagers' preference for traditional health services is rather motivated greatly by the patient-healer relationship from previous experiences [19,20]. Most people affirm that they express themselves freely in their choice of language and understand the explanations given to them by their traditional attendants. Traditional birth attendants and other local healers are said to be very compassionate to the sick, providing the required psychosocial support. Their holistic approach ensures that the biological, social and spiritual equilibrium of patients are restored. Patients can even be treated at home without immediate payment. Such emotional, cultural and respectful supports are essential for safe delivery [21, 22].

On the contrary, conventional health workers are said to attend to patients depending on the amount of money received. Even emergency cases like accidents and deliveries are neglected if no advanced payment is made. Women complain about many forms of maltreatments during delivery. They are often under-looked, insulted and neglected. They are usually attended to only when the child starts coming out. The socio-cosmic dimensions of health are neither understood nor taken into consideration given their lack of scientific evidence. Complains of possible supernatural entanglements expressed by these women are understandably not ignored. As such, the causes of some maternal deaths in health facilities are attributed to the poor patient-healer relationship. These disrespectful and inhumane services fundamentally deter the villagers from seeking hospital delivery [23-24]. It is only normal that the perceived appropriate solution to this is home delivery assisted by traditional birth attendants. The longstanding reputation of the latter, constructed on their proven reliability before the community's exposure to conventional medicine, remains a fundamental influence to many.

Dangerous hospital medications

Not many illnesses are preferably taken to conventional health facilities by the villagers for treatment. These illnesses, such as AIDS and cancer, are considered to be modern and from big towns brought by whites. Thus, they are best treated using the "white man's" medicine. However, the vast majority of prevalent illnesses are handled traditionally through the use of remedies consisting of natural elements like leaves, herbs, bark of trees, roots and animal parts.

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Without adding any chemical substance whatsoever during their preparation, these remedies are said to be harmless even when much of it is required for a given treatment. However, a contrasting perception is maintained towards medications prescribed and bought in hospitals. The villagers are convinced that they contain high concentrations of powerful chemicals that could lead to hazardous side effects. As such, they get rid of an illness but intoxicate and cause more dangerous illnesses.

The vulnerability of pregnant and nursing mothers makes them particularly at risk to such intoxication. Antimalarial prophylaxis during Intermittent Preventive Therapy and other antenatal prescriptions are considered dangerous. In this light, childbirths amongst many other conditions requiring oral intake of medications are scarcely entrusted to biomedical caregivers. It is believed that the said intoxication can be spontaneous leading to serious health damages and even instant death. They can equally be gradual, remaining in the patient's body and damaging his natural ability to fight against illnesses. Consequently, the cause of some maternal deaths is attributed to the use of medications during or even before pregnancy. In some cases, women die due to stillbirth from such foetal intoxication as highlighted by this testimony from a 65 year old female:

> *If not informed before delivery for appropriate actions to be taken, a woman going for childbirth who had earlier taken some powerful tablets has little chances of survival. The drugs can kill the child without anybody knowing. The longer a death child remains in a woman, the more she runs the risk of death. I once attended to a woman who was experiencing bleeding when her pregnancy has not yet come to term. I tried in vain to stimulate delivery but later discovered that the child was not responding because he had died long ago. She confessed that she took drugs against one of these new diseases. [---]. She died even before going half way the blood-giving treatment.*

Self-delivery

Being a typical agricultural community, with almost everyone involved in farming, the peaks of both planting and harvesting seasons are always so busy for villagers. Since everything must be done on time to ensure a good yield or to make sure that the planted seeds are not destroyed by animals, the villagers are obliged to spend several hours on their farms. They leave their homes before dawn and return at night fall. Some villagers practically spend up to a week in the farms to ensure that everything is properly done. TBAs are also as busy as any other farmer because their livelihood depends on their farm produce. Their recompense for assisting expectant woman is usually symbolic with little financial worth to cover their needs. This period is obviously a difficult one for pregnant women who are obliged to also work on their farms. They run the risk of not having an attendant around when needed, particularly when delivery starts. In this light, self-delivery is said to be common during this period.

The success rate of self-delivery, with respect to mother and child survival, is said to be very low [25, 26]. Self-delivery resulting from the absence of TBAs is thus perceived as a noteworthy cause to some maternal deaths in the village. It is believed that the assistance of traditional attendants, in reminding mothers about certain important requirements and actually helping out to perform them, is indispensable for a hitch-free delivery. There are important delivery practices that are supposed to be carried out and whose procedures are mastered only by these attendants. These include decontamination rituals, harnessing the totemic powers of both mother and unborn child, ensuring a suitable foetal posture for delivery amongst others. She is also greatly involved in the management of related complications such as large foetuses, illnesses, witchcraft, accidents and injuries which are all deadly if not properly attended to. As such, they are either poorly handled or completely unattended during these busy periods. The absence of birth attendants as a factor for maternal deaths is highlighted by a 46 year old male who holds that:

> *My own mother was a victim of the absence of birth assistants during the planting season. I was still very young when I was told to accompany her for planting in one of our farms because of the advanced state of her pregnancy. She suddenly started shouting in pains and told me to seek help from the neighbouring farms. I saw no one in both farms, so I ran home and told my father that mama was putting to birth in the farm. Since there was no attendant around, my grandmother was taken to deliver the baby. The baby came out safely but grandma could not stop the bleeding despite all her attempts. It was two days after that an attendant returned from her farm and stopped the bleeding but the blood-giving treatment was too late for her.*

CONCLUSION

Nchang community has a holistic perception of health which integrates the biological, social, cultural and cosmic environments of every community member.

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Hence, disequilibrium from any of these environments is often perceived as the origin of diverse morbidities and mortalities. Most of these do not correspond to the medical perspectives of conventional medicine which is basically limited to the (mal)functioning of the organs and systems of the human body. As such, skilled birth attendants in the local health centre lack the knowhow to appropriately understand and handle illnesses with socio-cultural and cosmic origins. Most explanatory models of health-seeking behaviors, like the Health Belief Model of Irwin Rosenstock and the Health Service Utilization model of Anderson [29, 30] hold that therapeutic preference is fundamentally determined by perceived etiology. In this light, the extensive homebirth preferences in Nchang are understandably the result of many ethnomedical perceptions attributing personalistic etiologies to maternal morbidity and death.

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ISSN (Online): 2455-3662
EPRA International Journal of Multidisciplinary Research (IJMR) - Peer Reviewed Journal
Volume: 7| Issue: 11| November 2021|| Journal DOI: 10.36713/epra2013 || SJIF Impact Factor 2021: 8.047 || ISI Value: 1.188

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