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COMPARATIVE STUDY OF KNOWLEDGE, ATTITUDE AND PRACTICE OF MIDWIVES ON ISLAMIC RULES OF MATERNITY CARE IN JALINGO LOCAL GOVERNMENT AREA, OF TARABA STATE, NIGERIA.

NAWATI Yakubu Shonzenba1[a,*], Dr Chiegil, Solomon Joseph[b], Dr. Goodluck Azuonwu[c], Dr. ID.Alabere[c], Cynthia Danjuma[d], SAMBO Mohammed Abdulrazaq[d], Danladi Danazumi Mungeri[d], Azuonwu,B.[e]

[a] *Taraba State College of Nursing and Midwifery, Jalingo.*
[b] *Global Healthplus Public Initiative, Nigeria*
[c] *University of Port Harcourt.*
[d] *College of Nursing & Midwifery Jalingo*
[e] *Ignatius Ajuru University of Education, Portharcourt, Rivers State.*

Abstract

Background:
Maternity care is still a mirage due to poor knowledge, attitudes and practice of Islamic rules of maternity care,
Objectives: The purpose of this study was to compare the Knowledge, Attitude and Practice of midwives on Islamic rules of maternity care in Jalingo LGA, Taraba state, Nigeria.
Methodology:
Descriptive comparative, cross-sectional survey design with multi-stage and simple random sampling techniques. The population for dissertation consisted of all Nurses and Midwives in two hospitals and Primary Health Care Centres and a sample size of 405 Nurses/midwives. Validated questionnaire was tested for reliability and validity with Cronbach Alfa, 0.80.
Results:
Mean age of respondents was 36.10(0.43)±8.21, Majority were married (77.5%), female (75.3%), Muslims (65.7%) , Hausa (45.6%) and those with RN and BNSc certifications (30.2/23.5%). Knowledge on 24-points scale scored mean = 19.24 (0.11) ±2.19, Attitudes on 28-points scale, mean =18.18 (0.16) ± 2.97 and Practice on 45-points scale, mean= 34.83 (0.10)± 5.71. Comparing how knowledge is spread across type of health facilities, score were mean= 16.5 (0.18)± 2.4 and mean = 16.7 (0.19) ± 2.5; t--1.001, P=0.318; mean = 15.3 (0.3) ± 3.6 for PHCCs and mean = 15.2 (0.3) ± 3.6, t-0.124, p=0.901 and Practices, mean = 17.6 (0.5) ± 6.4 for PHCs and mean = 17.7 (0.5) ± 6.6, t-0.114, p=0.915 for PHCCs and Hospitals respectively.
Conclusion:
Multi-cultural, ethno-religious practices and perceptions concerning maternity care has posed many influences on maternity care.
Recommendation:
It is therefore recommended that High quality/evidence-based and culturally competent care be initiated by the midwives.

Keywords: Comparing, Knowledge, Midwives, Islamic Rules and Maternity Care, Submitted: 2023-06-16 Accepted: 2023-06-17

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1. Background to the Study:

Globally, over two billion and approximately 2 million Muslims population live in the UK, constituting about 25% of the global population (Zouiten, 2023 and census, 2011). Contemporary literature has so far confirmed that Traditional beliefs and practices related to Islamic maternal care rules cannot be separated from pregnancy, childbirth, and the puerperium (Callister, 2015). Even though "preventable deaths of a woman" from pregnancy or childbirth are unacceptable (Maiwada, Mamat, Rahman & Rahman, 2018), antecedents to this phenomenon include Multi-ethnic, cultural, and religious beliefs (Kaur, Gupta, Purayil, Rana and Chakrapani, 2018). Unskilled nursing care is leading in sub-Saharan Africa, especially Nigeria, believed to be the will of Allah and is related to the use of Arabic calligraphy, preference for Traditional Birth Attendants (TBAs), cord cutting with unsterilized objects by **"wanzami",** Female Genital Mutilation (FGM) and Purdah System practices (UNESCO Intangible Cultural Heritage, 2023 and Callister, 2015). These practices are in no doubt related to knowledge inadequacy (ignorance), poverty, and negative attitudes enshrined in the practice of Islamic rules of maternity care and ethnocultural diversity (Maiwada, Mamat, Rahman & Rahman, 2018). It has deprived millions of mothers all over the world of access to good quality health services during pregnancy and childbirth, causing mortalities (Maiwada, Mamat, Rahman & Rahman, 2018) as reported by the World Health Organization. It is noted that every minute, a woman died from related complications during pregnancy and childbirth and even though accounting for only 2% of the global population, Nigeria's maternal death toll is reported to be about 20% of global deaths (WHO, 2019). This call for Increasing attention to improving the health of mothers during pregnancy, childbirth, and puerperium (WHO, 2011) through the provision of dignified maternity care,

* Corresponding author.
Email address: shozenbanawati47@gmail.com
(NAWATI Yakubu Shonzenba1)

(Mboho et al., 2013). This is because all women are considered a vulnerable population and should be cautiously handled during delivery to give birth under an experienced midwife who can adequately handle complications such as postpartum hemorrhage (PPH). Unfortunately, poverty, illiteracy, the improper budget allocation of Nigeria's health care system, implementation of health policies due to poor governance, and lack of trained medical staff have always been a problem (Kaur, Gupta, Purayil, Rana and Chakrapani, 2018).

A challenge to midwives remains how to address certain religious principles and customs, to meet the specific needs of Muslim women (Chiswick & Mirtcheva, 2010); however, studies rarely examine the social determinants of the inclusion of religion in the health setting, religion remains a social system that plays an important role in the formation of healthy behaviors of individuals and communities through its influence on lifestyles, worldviews and motivations (Maiwada, Mamat, Rahman & Rahman, 2018). Nevertheless, most religious groups have different perspectives on health care and health issues. Studies show that the cause of maternal death in developing countries is mainly due to poor access to maternal health care, poor antenatal and maternity care, as well as inadequacies in available care (Igbokwe, 2012). The Demographic and Health Survey affirms that maternal deaths are not simply a result of treatment failure; rather they are the outcome of a multifaceted interplay between a myriad of social, traditional, and economic factors (Majrooh et al., 2014). The behaviors, customs, superstitions, and tribal or ethnic codes of conduct of Muslims are guided by religious values and practices (Maiwada, Mamat, Rahman & Rahman, 2018). This may mean that their shared religious politics bring about common healthcare needs and challenges including for example, the need for treatments that meet Islamic lawful requirements (and not accepting what it considers as "haram" for the source of medicines) as "It is not a cure, it is a disease" (Islam on line, 2023). Coleys (2012) advocates that nurses and midwives are up to date on their knowledge and skills, by taking part in appropriate and regular

learning and professional development activities to uphold and develop their professional competence and improve their performance. They offer woman-centered care involving a flexible and concerted care model that both respects and accommodates the needs of all women (Beek, McFadden & Dawson (2019), and belief that maternity care for Muslim women best meets the needs of Muslim women and highlight the prominence of effective communication in providing culturally and religiously appropriate woman-centered care for Muslim women (Maiwada, Mamat, Rahman & Rahman, 2018). Globally, the Muslim faith embraces multi-ethnic diversities with diverse views regarding illness/illness behaviours and healthcare services (Shepherd, Harries, Spivak, *et al (2021)* which can impact the decision-making process, family dynamics, health practices, risks mitigation, and use of healthcare services to meet needs of the Muslim women in the context of their own culture and beliefs (Rassool, 2014a). In underdeveloped countries like Nigeria, Contemporary evidence shows that 99% of maternal mortality occurs as a result of complications of pregnancy and childbearing (Fathalla, 2019) and Cultural background as well as Islamic rules of maternity care being contributors (Addai, 2010). Addai also noted that health services exist alongside indigenous healthcare services in most rural societies in Africa enabling women's choices between the options. The use of modern health services in such a setting is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of individual women (World Health Organization et al., 2012).

Therefore, this study seeks to Compare the Knowledge,

Attitude and Practice of Midwives on Islamic Rules of Maternity Care in Jalingo Local Government Area of Taraba State, Nigeria was aroused by the high rate of child deliveries outside health facilities in parts of Nigeria to seek traditional help before consideration for formal health care delivery systems. The researcher noticed with keen concern how Muslim women in Jalingo, North Eastern Nigeria so much believe in ummah clinics over government hospitals and primary health care centers (PHCCs).

Hence, this study was guided by the followings Objectives:

To compare the level of knowledge on Islamic rules of maternity care in Jalingo L.G.A, Taraba State.

To compare the attitude of midwives on Islamic rules of maternity care in Jalingo L.G.A, Taraba State.

To compare the level of practice of midwives on Islamic rules of maternity care in Jalingo L.G.A, Taraba State

2. Methodology:

2.1. Research Design:

This study uses a descriptive comparative cross-sectional survey design.

2.2. Research Setting:

This study was conducted in Jalingo for a period of six weeks within June and July, 2021. Jalingo is the capital city of the state of Taraba, a geopolitical area in northeastern Nigeria. Jalingo Local Government Area was founded in 1991 and has an estimated population of 212,706 NPC (2019), coordinates 8* 54'N 11* 22'E, area: 401km2 Density 467.3 / km2Mumuye, Hausa / fulanis, Mambilla, jukun, kuteb wurkun, jenjo, chamba are the main tribes and many other local languages. Location of the palaces of the Emirate of Muri and Jalingo, Nigeria, the city was built during the era of Muslim Jihad To the west is the ArdoKola local government district, to the north is the Lau local government district, to the east is the Yorro local government district and to the south is the Gassol local government district (Bugard, 2014). In 1991, the state of Gongola was divided into Adamawa and Taraba and Jalingo became the capital of the state. Jalingo is located along Yola and Wukari Road. The local government area has 10 political districts, including: Turaki A, Turaki B, Sintali', Mayogwoi, kashalasembe, kona, Sarkin-Dawaki, Barade, Majidadi and Yelwa Abbare. The local government area consists of two (2) hospitals (Federal Medical Center and Specialist Hospital) and 28 health centers,

of which 26 are active and 2 are temporarily closed due to unsafe conditions.

2.3. Study Population:

The target population included all nurses and midwives involved in maternity care in Jalingo Local Government Area.

2.4. Sample and sampling technique:

A multi-stage sampling technique was used in this study. First of all, Jalingo LGA was selected randomly, followed by a purposive sampling of all active Hospitals and PHCCs (Federal Medical Center (FMCJ), Jalingo; State Specialized Hospital (SHJ) and twenty-six (26) primary health Centres (PHCCS)) Summarized viz:

2.4.1. Stage 1:

The sampling frame was obtained from the three categories of Health Care Facilities in Jalingo. L.G.A

2.4.2. Stage 2:

Percentage proportionate was used to determine the number of Staff recruited for the study.

2.4.3. Stage 3:

Simple Random technique was used to select the respondents from each of the three categories of health facilities. Sample Size of 405 was used for the study using the computation formula:

Where SEM= Standard Error of Mean
= Variance = pq
P = 50% =0.05
q = 50% = 0.05
= Margin of Error (ME) = 1.96
Substituting the values,
Substituting the value we then have = 384

The calculated sample size was 384, but to account for the losses and incompleteness, it was increased by 5%, thus, 384 x 5% = 19.2 (20) (+ 384) = 405. Therefore, 405 midwives were recruited for comparative research as represented below:

2.4.4. NOTE: Stage 1:

Sample frame was obtained for the three categories of Health Care Facilities in Jalingo. L.G.A

2.4.5. Stage 2:

Percentage proportionate was used to determine the number of Staff recruited for the study.

2.4.6. Stage 3:

Simple Random technique was used to select the respondents from each of the three categories of health facilities.

Hence, the number of questionnaires is to be administered for each Hospital and health care centers accordingly.

Federal Medical Centre Jalingo (FMCJ) Midwives:

3. 5/100 X 405= = 107 326

State Specialist Hospital Jalingo (SSHJ) Midwives:

4. 5/100 X 405 = = 103 275

Health care Centres Midwives:
48/100 X 405 = = 194.4
Total 107.326 + 103.275 + 194.4 = 405

4.1. Inclusion Criteria:

All staff and student midwives working or who are in their clinical posting in:

Specialist Hospital and Federal Medical Centre

All twenty-six (26) healthcare centers in Jalingo PHCCs were enrolled in the study.

4.2. Exclusion Criteria:

CHO, CHEW, JCHEWs, and Staff who are neither nurses nor midwives in the health centers were excluded from the study, and because other health centers do not have midwives, the time factor, some facilities that are temporarily closed for insecurities.

4.3. Instrument for Data Collection:

Validated questionnaires were used to generate relevant data. The content of the questionnaire was divided into four parts (A to D). Part A (Socio-demographic characteristics of respondent). Part B (level of knowledge of Islamic rules

Table 1: Allocation of Respondents

S/No.	Name of the Health Facility	Total Number of Staff	Number Selected
1.	Federal Medical Jalingo (FMCJ)	119	107
2.	State Specialist Hospital Jalingo (SSHJ)	115	103
3.	Primary Health Care Centres (PHCCs)	216	195
	Total	450	405

of maternity care/obstetric care. Part C (The attitude of midwives towards Islamic rules of maternity care With Modified Likert scale response pattern, SA: agree, A: agree, D: disagree SD: disagree, they will be hired), Part D (The level of practice of midwives on Islamic rules of maternity care with 1 = always; 2 = often; 3 = occasionally; 4 = rarely; 5 = never response pattern.)

4.4. Validity of the Instrument:

The surface and content validities of the self-structured questionnaire were corrected and revised by the researcher's supervisor in terms of relevance, clarity, and ambiguity. In addition, validation of the questionnaire was done by two lecturers from the Department of Nursing Sciences University of Port Harcourt and one from ACEPUTOR. The final correction was incorporated in the final questionnaires.

4.5. Reliability of the Instrument:

The reliability of the instrument was done using Test-retest and a Pilot's study done by administering questionnaires to the 38 respondents in two (2) hospitals and 26 Health care centers.

4.6. Method of Data Collection:

Data was collected using validated questionnaires developed by the researchers. Researchers use direct delivery to distribute questionnaires to respondents. The respondent filled out the questionnaire and returned it immediately.

However, five research assistants were recruited and trained based on the purpose, objectives of the research, sampling procedures, and the use of informed consent, who assisted in the administration of the questionnaires.

4.7. Method of Data Analysis:

Data were analyzed by the use of computer software, SPSS version 21.0, T-test, and ANOVA used to compute statistical associations between data levels of Knowledge, attitudes, and practices (K.A.P) related to Islamic maternity care rules. Descriptive statistics and inferential tests with a significance level of 0.05 to determine the characteristics of the research object.

4.8. Bias:

Efforts were made to analyze data using appropriate statistical methods, random sampling, and blinding was done for data analysts, efforts were made to account for lost questionnaires and incompleteness, and all outcomes were completely reported.

4.9. Ethical Consideration:

A letter of introduction was obtained from The University of Port Harcourt followed by ethical approval from the research ethics committee of Federal Medical Center (FMC), Jalingo. permission to conduct the research was obtained from the CMD, FMC, Jalingo, ES, PHCDA, and all heads of health facilities. Informed consent was also obtained from each research participant who met the inclusion criteria. Respondents ensured confidentiality and anonymity through the information they shared. Before entering the hospital and PHCCS, the purpose of the research was explained to them in the questionnaire and they were free to decline participation at any stage of the study.

5. Results:

5.1. *Demographic Characteristics of Respondents (N=364):*

The study recruited 405 eligible participants with a return rate of 90% (364), who responded to the questionnaire. Of these, 48.8% (20) declined participation, 24% (10) dropped out and 26.8% (11) accounted for incompleteness in filling the questionnaire.

Results showed that the age range of respondents was 20 to 60 years of age, with a mean score of 36.10 and a standard deviation of 8.209 (see Table 2).

Most respondents were married (77.5%), female (75%), Muslims (65.7%) who worked in secondary and tertiary Hospital settings (50.9%) of Hausa (45.6%) ethnic origin and RN / BNSc professional qualifications (30.2 %).

5.2. *The socio-demographic characteristics of the respondents are found in Table 1.*

5.3. *Level of knowledge of Islamic rules of maternity care:*

In this study, knowledge was considered as 12 items to assess the midwife's knowledge of the Islamic rules of motherhood. As a result, as shown in Table 4.3, 80.5% of the participants knew that the Islamic rules of maternity care refer to the Islamic law that governs the Muslim world in terms of care during pregnancy, childbirth, and postpartum care for women, including female genital mutilation, umbilical cord cutting and placental rituals of use of unsterilized sharp objects, early or forced marriages, nutritional taboos, and breastfeeding, etc. (53.3%). 49.7% of people know that women frequently patronizes private Islamic clinics (Ummah) and TBAS (58.5%) more than public hospitals (northern Nigeria) for pregnancy care causing an impact on maternal and infant wellbeing. Approximately 70% of the people know that the decision-making power of Muslim women is under the control of their husbands or elders and therefore the wives lose their autonomy to the men. For details on this information.

Level of knowledge on the 24-point scale recorded a mean score of 19.24 (0.11) ± 2.19 being 80.2% of the maximum score (a very high level of knowledge of Islamic rules of maternity care. (See Table 2)

5.4. *Attitudes to the practice of Islamic rules of maternity care:*

In this study, Respondents' attitudinal disposition was tested towards the practice of Islamic rules of maternity care. About 50.8% of the respondents Respect Islamic rules of touching, privacy & confidentiality, 79.7% belief that those who hold nutritional taboos are logical in their way, 53.6% belief that it is abnormal to neglect patients during maternity care because they are rude and aggressive, 72.3% do not belief that colostrum, the first milk is bad, causes illness and should be discarded and 60.4% belief that respectful maternity care is unconditional so midwives should practice it whether or not patient is polite.

Attitudes to the practice of Islamic rules of maternity care on a scale of 28-points reported a mean score of 18.18 (0.16)±2.97 being 64.9% of the scale (an above-average level of attitude to the practice of Islamic rules of maternity care. (See Table 2).

5.5. *The practice of Islamic rules of maternity care:*

This section consisted of 9 items: Self-Reported Practice of Islamic rules of maternity care. It enquired how often respondents did certain activities that contributed to their practice of Islamic rules of maternity care. In this study, 89.1% of the respondents educated women on complications related to pregnancy and childbirth as a result of the use of unsterile sharp objects by "wanzami" as an Islamic practice, 86.9% Attempt to prevent high-frequency infections amongst people who practice purdah system (female seclusion) by Muslim ummah, 17.3% do not touch, invade privacy and confidentiality. They are educated to avert the belief that colostrum is bad (84.4%), the effects of some Islamic practices (85.5%), and the need to refer pregnant women early for delivery (92.1%).

Table 2: **Frequency distrIbution of demographic characteristics of respondents in this study**

Variables	***(N = 364) **N**	**(%)**
Gender		
• Male	90	24.7
• Female	274	75.3
Marital Status		
• Married	282	77.5
• Single	68	18.7
• Divorced	5	1.5
• Separated	9	2.5
Religion		
• Christianity	113	31
• Islam	239	65.7
• Traditional	12	3.3
Education		
• RM	72	19.8
• RM/ RN	60	16.5
• RM/ BNSc	85	23.5
• RN/ BNSc	110	30.2
• Others	37	10.2
Health System	**Level**	
• Primary (PHC)	179	49.2
• Secondary	77	21.2
• Tertiary	108	29.7
Ethnicity		
• Mumuye	37	10.2
• Kona	37	8.8
• Hausa	166	45.6
• Fulani	68	18.7
• Others	61	16.8

****Respondents in this study

This information is found in Table 4.6. The Self-reported Practice of Islamic rules of maternity care on a scale of 45-points reported a mean score of 34.83 (0.10)±5.71 being 77.4% of the maximum score on the scale. This means the Practice of Islamic rules of maternity care was high. A summary of Descriptive statistics for the analysis of variables is shown in Table 3.

5.5.1. Comparisons for level of knowledge:

In this study, knowledge was measured on 24-points scale and recorded 16.5 (0.18) ±**2.4** for primary Health Care Midwives and 16.7 (0.19) ±**2.5** (P=0.318) for Midwives in hospitals. This showed that there is no significant difference in knowledge of Islamic rules of Maternity care.

5.5.2. Comparisons for level of attitude:

Attitudes of Hospital and Health Centre midwives towards Islamic rules of maternity care were considered as seven items on a 28-points scale and reported a mean score of 15.3 (0.3)±3.6 and 15.2 (0.3) ±3.6 (P=0.901) respectively with no significant difference.

Table 3: **Summary of Descriptive Statistics for Respondents in this study (N=364)**

Variable	Scale of measure	Mean	SE	SD
Knowledge	24	19.24	0.11	2.19
Attitude	28	18.18	0.16	2.97
Practice	45	34.83	0.10	5.71

SE: Standard Error of Mean; SD: Standard deviation

5.5.3. ***Comparisons for the level of practice:***
The practice of Islamic rules of maternity care was compared among Hospital and Health Centre midwives and reported a mean score of 17.6 (0.5) 6.4 for primary Health Center Midwives and 17.7 (0.5) 6.6 (P=0.909) for Midwives in hospitals with no significant difference.

5.6. ***Hypotheses Testing:***

In this study, four (4) null hypotheses were tested to determine the relationship between variables.

Ho: 1. There is no statistically significant difference in the knowledge level of Islamic maternity health care rules between Hospitals and PHCC Midwives. The results of this test show that there is no significant difference between the knowledge levels of Islamic maternity health care rules. Hospital (16.7 (0.19)) 2.5) and health center midwives (16.5 (0.18) 2.4) p = 0.318 maternal rate in Jalingo LGA in Taraba state

Decision Rule: In this case, we accept the null hypothesis and reject the alternative

Ho: 2. There is no statistically significant difference in the level of attitudes regarding Islamic maternity care rules between Hospitals and PHCC Midwives in Jalingo LGA, Taraba state

According to the results, there is no significant difference in the attitudes of midwives toward Islamic nursing rules. Hospitals in Jalingo LGA, Taraba Midwife (15.2 (0.3) 3.6) and health center midwife (15.3 (0.3) 3.6) p = 0.901.

Decision Rule: Therefore, we accept the null hypothesis and reject the

Ho: 3 There is no statistically significant difference in the practice level of Islamic maternity care rules between Hospital and PHCC Midwives in Jalingo LGA, Taraba State

Results Show that there is no statistically significant difference in the practice level of Islamic obstetric care rules between hospital midwives (17.7 (0.5) 6.6) and health centers (17.6 (0.5) 6.4) in Jalingo LGA with p = 0.915.

Decision Rule: Therefore, the alternative hypothesis was rejected and the null hypothesis was supported.

Independent sample T-test showing the relationship between means for Knowledge, attitude, and practice amongst Health center and hospital midwives in this study

6. Discussion of Major Findings:

The aim of this study was to compare the Knowledge, Attitude and Practice of midwives on Islamic rules of maternity care in Jalingo LGA, Taraba state, Nigeria:

The study revealed that knowledge of Islamic rules of maternity care was high level as interviewees know that Islamic maternity care standards refer to Islamic law, which governs the care of women in the Muslim world during pregnancy, childbirth, and the postpartum period, including female genital mutilation, cutting of the umbilical cord, and placental ceremonies with non-sterile items by traditional surgeons (Manzani), Early marriages or forced marriage., Participants also know that female Muslims patronize Islamic health clinics (Ummah) frequently and consider it more important than public hospitals (in northern Nigeria) including attendants by the traditional birth attendants (TBAS) for pregnancy care. participants also know that the high rate of birth outside of medical institutions in most of Nigeria can be attributed to seeking traditional help outside formal settings before resorting to a formal health care delivery system. These findings agree with

Table 4: **Mean Scores Comparisons for KAP and Factors in Islamic rules**

Variables	Max. Score	Primary (N=179) (SE)	± SD	Hospitals (N=185) (SE)	± SD	P- value
Knowledge	24	16.5 (0.18)	2.4	16.7 (0.19)	2.5	0.318
Attitude	28	15.3 (0.3)	3.6	15.2 (0.3)	3.6	0.901
Practice	45	17.6 (0.5)	6.4	17.7 (0.5)	6.6	0.909

Table 5: **ANOVA comparing means for KAP of Midwives on Islamic rules**

	Source of variation	Sum of squares	Df	M S	F	P- value
Knowledge	Within	2237.8	362	6.182		
	Between	8.189	1	6.189	1.001	0.318
	Total	2244.0	363			
Attitude	Within	4756.9	362	13.141		
	Between	0.203	1	0.203	0.015	0.901
	Total	4757.15	363			
Practice	Within Between	15398.6 0.557	1	0.557		
	Total	15399.1	363		0.13	0.909

Table 6: T-test Comparisons scores for KAP of midwives on Islamic rules)

Variables	Max. Score	Primary (N=179) (SE)	± SD	Hospitals (N=185) (SE)	± SD	t- value	P-value
Knowledge	24	16.5 (0.18)	2.4	16.7 (0.19)	2.5	-1.001	0.318
Attitude	28	15.3 (0.3)	3.6	15.2 (0.3)	3.6	0.124	0.901
Practice	45	17.6 (0.5)	6.4	17.7 (0.5)	6.6	0.114	0.915

the Research results reported by Akokuwebe et al. (2016)who discovered that women in sub-Saharan Africa have the habit of seeking spiritual counseling, traditional health care, and faith treatment before seeking modern health services. In this case, Akokuwebe et al. emphasized that midwives with adequate cross-cultural knowledge and skills should provide personalized midwifery-led care or obstetric care to women with low socioeconomic status and different religious backgrounds and called on women to insist being attended to, by adequately prepared Midwives during pregnancies and childbirth. It is understood that in Islam, the wife does not have autonomy, she is under the control of the husband, and mother-in-law and so this makes women and their babies vulnerable. To protect the interest of these women, midwives make decisions about Muslim women and advocate for their safety, especially when their trade-religious practices deprive the women of access to the healthcare services they need (Akokuwebe et al., 2016). It has been found that knowledge of education about Early marriage, childbirth preparation, and financial planning for childbirth greatly reduces mortality because Preparation for childbirth has also been shown to be influenced by cultural beliefs" (WHO et al., 2010).

Attitudes to the practice of Islamic rules of maternity care show a majority of the respondents Respect Islamic rules of touching, privacy, and confidentiality. They believed that those who hold nutritional taboos are logical in their way, it is abnormal to neglect patients during maternity care because they are rude and aggressive, do

not believe that colostrum, the first milk is bad, causes illness, and should be discarded and that respectful maternity care is unconditional so midwives should practice it whether or not patient is polite. Attitudes to the practice of Islamic rules of maternity care reported and above average level And comparing Self-reported

6.1. Attitudes of Hospital and Health Centre midwives towards Islamic rules of maternity care showed no significant difference:

Results showed that there is no substantial difference between the factors for the practice of Islamic rules of maternity care among Hospital and Health Centre midwives in the Jalingo local government Area, Taraba State.

Contrary to the above findings, the National Primary Health Care Development Agency (2019) observed that women in labor complained of unfriendliness, rudeness, aggressiveness, abusive attitudes, and above all inadequate respectful maternity care, which the women claim as factors influencing their choice of delivery site.

In this study, the practice of Islamic rule of maternity care shows that respondents educated women about pregnancy and childbirth-related complications of the use of sharp objects that have not been disinfected by "wanzami". Participants tried to prevent the high frequency of infections among people who practice pudah system (female seclusion) by Muslim Uma- do not touch, infringing on privacy and confidentiality. They are educated to avoid believing that colostrum is not good, the influence of some Islamic customs, and the need to refer pregnant women for delivery to advanced settings where midwives exist. In this study, Self-reported Islamic rules of maternity care reported high levels.

The practice of Islamic rules of maternity care was compared among Hospital and Health Centre midwives and reported to have no statistically significant difference between the level of practice of Islamic rules of maternity care between Hospital and Health Centre midwives in Jalingo local government Area, Taraba State. A contrary report to this finding is that of the statistical survey of Grønvik & Fossgard Sandøy (2018) which reported that children (girls) 12 and 13 years old, showed many complications of maternal mortalities consisting; Eclampsia, the Occluded Labor Force and complications of safe abortion

Also, Salami et al., (2016) stating that certain cultural practices (the practice of purdah system, female circumcision or FGM, cutting the umbilical cord by "wanzami" with non-sterilized objects, early or forced marriage, etc.) are observed as responsible for maternal mortality and babies in Nigeria and Sub-Sahara African Society. Furthermore, the practices of multi-ethnic cultural beliefs and unskilled nursing care are leading the way in sub-Saharan Africa, especially in Nigeria (Rassool, 2014a). Good and harmful associations with women's sociocultural issues, beliefs, poverty and women/husband's low education and employment levels, age, and family income have negatively affected the practices and perceptions of maternal care (Navaneetham & Dharmalingan, 2010).For example, the use of Arabic/calligraphic characters in childbirths. Nigeria has shared a disproportionately heavy burden in the global maternal and newborn mortality rate. Nigeria is the first and second country with the highest number of maternal and neonatal deaths in the world, respectively. These poor indices may be related to factors related to the practice of Islamic maternal health standards (Rassool, 2014a).

6.2. Implication for Nursing/Midwifery:

Knowledge improvement; attitudes, practices, and problems related to obstetric care practices, and access to skilled midwives have provided panacea or better quality Hospitals and health centers they deliver and take care of mothers and their newborns in our contemporary community before, during, and after delivery, and solve all three delay models related challenges. Lack of qualified health personnel is considered to increase maternal and infant mortality Standards. In addition, midwives must be educated, knowledgeable, community-based, culturally competent, compassionate, and respond to the coherence of multiple socio-economic and ethnic religions. Cultural competence is the ability of

healthcare workers and facilities to reduce practices and factors related to Islamic rules through training and formulating policies and procedures and to provide healthcare services that suit the cultural, social, and religious wishes of mothers and their families. It is the midwives roles to apologize for cultural mistakes, be aware of the uniqueness of Muslims and their special needs, maintain respect in everything they do, identify Muslim brothers who can support the traditional sensitive care of Muslim patients, identify the language bodyand Face, observe how beliefs and behaviors affect others. Better health requires women and children to receive quality services from before conception and pregnancy to delivery, postpartum, and child health outcomes. As already pointed out, many low-income and middle-income countries (LMIC) still have high maternal, newborn, and under-five mortality rates (WHO 2015).

7. Conclusion:

The study concludes that the Islamic maternity care rules (pregnancy, childbirth (birth), and postpartum) generally address the four goals; regarding the Islamic maternity care rules and Knowledge level, attitude the practice levels have no significant difference between the Primary Health Care Center Midwives and the Midwives working in Hospital settings.

8. Recommendations:

Based on the findings of the study, the following recommendations are made:

8.1. To ***Health workers (midwives) training institutions:***

I. Midwives should cultivate a positive attitude in a multi-cultural, multi-religious setting to offer acceptable care that will be acceptable to all regardless of religion, tribe, or culture.

II. Midwives should carry out similar and related research and embark on capacity building for lower cadre midwives to cultivate a well-trained workforce.

III. Midwives should educate all women to be aware of complications and effects of delay in seeking care under trained personnel

IV. Midwives should collaborate with the trado-religious caregivers and educate them on the need to refer these women for expertise care under the trained midwives

V. Midwives should advocate for women so that they can have a voice in the community and express their voices and overcome cultural practices that harm women and babies.

VI. Mutually respectful obstetric care midwives must demonstrate cultural awareness and sensitivity.

Vii. Midwives should use interpersonal relationships to discuss customer/patient bill of rights, maintain privacy, confidentiality, and patients' right to respect and Women improve their basic rights.

8.2. To ***religious organizations:***

a. Religious bodies should explore knowledge and understanding of cultural vitality, and factors related to practice, such as religious factors, ethnicity, etc.

b. Religious leaders(Imam) should educate members on the need for the right approach in seeking care (plan to bridge the gap between Islamic rules in pregnancy care practices).

8.3. To the government:

1. Government should have Strong political will to support the midwives**, train and retrain them,** and support them to actively participate in conferences.

2. Local, state, and federal legislatures to enact laws restricting female genital mutilation (FGM), early marriage, forced marriage, and enforcement of nursing decisions; due to "wanzami" and cultural beliefs that lead to dangerous behavior.

3. Government should review the financial/budgetary allocation of the health sector; as recommended by WHO to ensure monitoring, evaluation, and supervision, good governance/policies and plans, and Gender equality and women's rights, as well as opportunities for

empowerment of young people, instability and insecurity must be addressed to avoid unnecessary challenges

4. Government should Ensure adequate staffing/capacity building: Emphasize training, government staff retraining, and infrastructure (facility) funding resources because the partnership between government and NGOs is the basic leadership to overcome health system problems: planning, Organizing, guiding, controlling, provide and review the priority needs of the people they care for, and promote interprofessional and inter-professional skills to continuously ensure the improvement of ethnic religions, cultural beliefs, and various factors during obstetric care.

8.4. To the society at large:

i. The community should support the midwives in their fight for the betterment of their health and wellbeing.

9. Limitation of the study:

Some participants declined participation because the study was related to religion, There was limited time to carry out the study, and lack of financial support.

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11. List of abbreviations:

NGO: Non-Governmental Organization
WHO: World Health Organization
LMIC: Low-Income and Middle-Income Countries
RN; Registered Nurses
BNSc: Bachelor of Nursing Science
ES: Executive Secretary
PHCDA: Primary Health Care Development Agency
FMC: Federal Medical Center
CMD: Chief Medical Director
TBAs: Traditional Birth Attendants
UNESCO: United Nations Educational, Scientific and Cultural Organization
FGM: Female Genital Mutilation
PPH: Post Partum Heamorrhage
PHCCs: Primary Health Care Center

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Location: Wisdom Centre, P.O.BOX. 148, Uganda, East Africa.

Author biography

NAWATI Yakubu Shonzenba1 Principal Investigator

Dr Chiegil, Solomon Joseph Doctor of public Health, Global Healthplus PublicInitiative, Nigeria