PERCEPTIONS OF OROFACIAL CLEFTS AMONG PREGNANT WOMEN IN RURAL NIGERIA.

This study was conducted under project 'Bridge a Cleft' as part of the Student Leadership in Global Oral Health Program.

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BACKGROUND

A recent study in Nigeria reported a prevalence of orofacial clefts of 0.5 per 1000 live births (1) Although this is a statistic lower than the global prevalence (2), a lesser proportion of Nigerians understand and seek proper care for this orofacial deformity.

Myths surrounding the etiology of orofacial clefts are prevalent in Nigeria A recent study in Nigeria, highlighted the prevalence of poor knowledge of the etiology of orofacial clefts as 51 of mothers believed that orofacial clefts were an "act of God," or as a result of "evil spirits" and "wicked people" (3)

These erroneous cultural beliefs create stigmatization against children born with orofacial clefts. Mothers of children born with orofacial clefts have reportedly stated that they were ashamed of having such a child, with some expressing extreme ideas such as wishing the baby was never born and abandoning the child in the hospital (3). The effects of cultural stigmatization on children born with orofacial clefts are widespread, and can lead to poor health seeking behaviors, as well as mental and emotional trauma on the child and the mother.

OBJECTIVE

To examine the perceptions and attitudes towards orofacial clefts, among pregnant women accessing antenatal care in a rural primary health center in Ibadan, Nigeria.

METHODOLOGY

A pilot study, using the quantitative approach, and a cross-sectional design, was conducted among 61 pregnant women receiving antenatal care at a primary health center in Ibadan, Nigeria. A cross-sectional design was chosen to assess the prevalence of poor perception and attitude in the group.

Data was collected through questionnaires comprising of 30 questions divided into four sections that assessed their perception of the causes of orofacial clefts, and their attitude towards orofacial clefts. Participants were graded based on their responses, and grouped into two categories: poor and good attitude/perception. Internal and external validity checks were conducted.

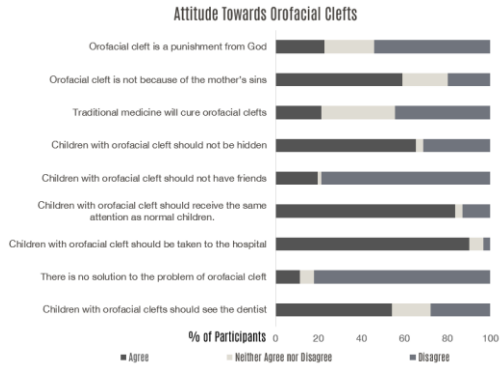
DATA ANALYSIS

The Statistical Package for Social Sciences (SPSS) version 26 was used to analyze the data. Univariate Analysis was conducted using means, standard deviations and frequencies. Bivariate Analysis was conducted using chi square tests and independent samples t-test to determine the factors associated with perceptions and attitudes. The level of statistical significance for all tests was set at **5%**.

Fig 3: Staff at the antenatal clinic

Fig 1: Primary Health Care Centre

Fig 2: Pregnant women attending the antenatal clinic



RESULTS

The mean (±SD) age of participants was 29.4 (±5.5) years with an age range of 18-43 years. 77% were from the Yoruba tribe and 52.5% of the participants were Muslim. The Yoruba tribe is the most predominant tribe in the Southwestern part of Nigeria. 44% of participants had poor perception of the causes of orofacial clefts with some (30%) stating that it was and act of God, while others (14.8%) stated that it was due to evil spirits and spiritual attacks. 41% of participants had poor attitude towards orofacial clefts.

Both participants with lower levels of education (75%) and participants with higher levels of education (69%) had a poor perception of the causes of orofacial clefts (p=0.600). More (53.1%) participants with lower levels of education had a poor attitude towards orofacial clefts compared to those (46.9%) with higher levels of education (p=0.043).

DISCUSSION

Poor perceptions of the causes of orofacial clefts was a notable finding in this study. This could be a result of negative cultural beliefs surrounding congenital abnormalities in the region. Poor attitudes towards orofacial clefts was noted among those with lower levels of education, as well as those with higher levels of education. This comes to show that environment, culture and community, rather than education, may play a larger role in determining the attitude of participants towards the disease.

CONCLUSIONS

There is a need for interventions aimed at educating the community of the causes of orofacial clefts. This will improve the perceptions of the community towards orofacial clefts, and might in turn, improve their attitude towards the disease. Ultimately, these interventions will aid in reducing the burden of the stigma associated with orofacial clefts and contribute towards better health outcomes for children born with orofacial clefts.

REFERENCES