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Multiparity In Timor-Leste, Risk Factor Associate the Midwife Intervention in Center Health of Community Ainaro Timor-Leste

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Abstract
Introduction*: East Timor has changed dramatically. Since its independence just a decade ago, it has a post-conflict country to a developing country to lower middle-income. As the country experienced the socio-economic progress and security in recent years, multiparity situation in Timor-Leste has also gradually improved. However, there are several challenges that still affect many children born in the same family in East Timor. The analysis of the overall situation of the family having many children is imperative to ensure evidence-based actions to address the remaining challenges in the country's changing context.* ***Objective****: The objective of this thesis is to know the factors of multiparity; Identify the knowledge of women about the risk of multiparity; Knowing what the perception of women on the intervention of the midwife in the risk of Multiparity.* ***Method****: This research is a study of exploratory and descriptive. The sample is composed of 30 pregnant women who attended antenatal Ainaro Health Center in the central part of East Timor. The data collection collected in the period from 5 October to 6 November 2015.* ***Result and Discussion:*** *Multiparity provides strong reasons such as assisting a family continuation of generations, care for the parents when they are elderly.* ***Conclusion:*** *This study indicates that, although few women in Ainaro district are aware that there are dangers associated with high birth, but most of our respondents do not think that there are health risks associated with having many children. With their education, they think that high birth women feel that having many children was harmless to your health. This number is significant, considering the implications of high parity on maternal and neonatal morbidity and mortality and long-term, socio - economic. This is more so when viewed considering a total of high fertility in East Timor in an economy that is not developed.*
Keyword: Multiparity; Risk Factor; Midwife intervention;

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Introduction

Planning and organizing the family is a matter of humanity. This policy is being implemented by the government of East Timor. If a country's development is a based-on human develop mint the birth rate must also be regulated. Measures must be regulating. Measure must be taken so that there is a balance between production and birth rate. The government is concerns about the number of births, as this requires an increase in production, especially food production. Family planning must be done in a way that does not contradict the law in this country, nor the teachings of religion which is a source of morals and the sense of humanity. Multiparton is a woman who has completed two or more pregnancies to the stage of fetal viability (Lowdermilk, 2008). Parity is the number of pregnancies in which the fetus reached viability at birth and not the number of fetuses born, the fact that the fetus was born alive or dead after reaching viability does not affect parity.

Some of the factors related to multiparity are the low level of maternal education, low economic capacity of the family, social and cultural positions that do not allow a greater risk of multiparity to maternal and fetal death.

According to the World Health Organization (WHO) between 2009 and 2010, the maternal mortality rate in pregnancy and childbirth worldwide reached 515, 000 people each year, which means that every minute there is a mother who dies from to complication in pregnancy and childbirth at home.

According to the Demographic Health Report of East Timor (2009-2010) the fertility rate in women of reproductive age is 5.7, being 4.9 in urban area and 5.9 in the rural area. Also, according to the same report, maternal mortality in East Timor is still very high when compared to other ASEAN countries. The main causes of maternal mortality in East Timor are postpartum hemorrhage, prolonged childbirth, and puerperal infection. It should be noted that 78% of deliveries are carried out at home without the assistance of health technicians.

These data require a great effort in terms of prevention, surveillance of pregnancy and assistance during childbirth, to improve the county's health indicators.

Being aware of the existing reality in East Timor related in multiparity and the risks to women's health, we intend to investigate the factors that are related to multiparity and the action of midwives in this area

Method

This research is a study of exploratory and descriptive. The sample is composed of 30 pregnant women who attended antenatal Ainaro Health Center in the central part of East Timor. The data collection collected in the period from 5 October to 6 November 2015.

Result and Discussion

Result

Data analysis Characteristic

Regarding age, our sample consists of 30 participants, with and average age of 34.2 years, with the youngest participant being 23 years old and the oldest 42 years old. Regarding religion, it appears that all participants Catholic religion (100%)

Most participants are illiterate (11; 37%), the remaining participants (9;30%) have secondary school, the participants (5;17%) with pre-secondary school. Only one participant has a university, according to table 1

Table 1

Distribution of participants according to women's education

Level of Education	Freq	%
Illiterate	11	37
Primary school	4	13
Presecondary school	5	17
Secondary school	9	30
University	1	3
Total	30	100

Regarding the education of the husband of our participants, most attended primary school (13,43%), followed by secondary school (11; 37%), with a university there are two participants, according to table 2.

Table 2

Distribution of participant according to the education husband

Education	Freq	%
Illiterate	2	7
Primaria	13	43
Presecondary	1	3
Secondary	11	37
Under graduate D3	1	3
University	2	7
Total	30	100

The according of husband's age, it appears that the average age is 40.5 years, the youngest is 28 years old and oldest is 54 years old.

According to table 3, most participants report that the husband is unemployed (20; 67%) and employed (10; 33%).

Table 3

Distribution of participants according to husband's job

Job	Freq	%
Employed	10	33
Unemployed	20	67
Total	30	100

About women's employment, it appears that the participants in our study are all housewives (30; 100%). As for monthly household income, our participants, with an income of $ 50-100 have 26% 8 participant, 20%, 6 participants with $150-200. Only one participant (1;3%) has an income of $ 300. According to table 4

Table 4

Distribution of participants according to family income

Family income	Freq	%
(20-50)	2	7
(50-100)	8	26
(100-150)	5	17
(150-200)	6	20
(200-250)	5	17
(250-300)	3	10
>300	1	3
Total	**30**	**100**

Regarding the age of marriage of the women, on average it is 17 years old, with a variation between 14 and 26 years old, that is, in your study the participant who married

Regarding the age of marriage of the women, on average it is 17 years old, with a variation between 14 and 26 years old, that is, in our study the participant who married the youngest was 14 years old and the oldest was 26 years old. As for men, the average of marriage is 20 years from 16 to 40 years.

Table 5

Distribution of participants according to pregnancy history pregnancies Childbirths abortion perinatal death.

Pregnancy		Childbirths		Abortion		Perinatal death	
Freq	%	Freq	%	Freq	%	Freq	%
6	20	4	13.3	1	3.3	0	0
5	16.6	3	10	1	3.3	0	0
6	20	3	10	2	6.6	0	0
4	13.3	2	6.6	1	3.3	0	0
6	20	5	16.6	0	0	1	3.3
6	20	5	16.6	0	0	3	10
6	20	5	16.6	0	0	0	0
7	23.3	5	16.6	1	3.3	0	0
7	23.3	5	16.6	1	3.3	2	6.6
7	23.3	5	16.6	1	3.3	0	0
10	33.3	9	30	0	0	0	0
7	23.3	5	16.6	1	3.3	0	0
9	30	8	26.6	0	0	1	3.3
6	20	5	16.6	0	0	1	3.3
7	23.3	5	16.6	1	3.3	0	0
6	20	3	10	2	6.6	0	0
6	20	5	16.6	0	0	0	0
11	36.6	9	30	1	3.3	2	6.6
6	20	4	13.3	1	3.3	0	0
7	23.3	6	20	0	0	2	6.6
6	20	5	16.6	0	0	0	0
7	23.3	5	16.6	1	3.3	0	0
6	20	5	16.6	0	0	0	0
9	30	8	26.6	0	0	0	0
8	26.6	7	23.3	0	0	1	3.3
7	23.3	6	20	0	0	1	3.3
6	20	5	16.6	0	0	1	3.3
9	30	8	26.6	0	0	2	6.6
11	36.6	9	30	1	3.3	2	6.6
6	20	5	16.6	0	0	0	0
210	100	164	100	16	100	19	100

Pregnancy, childbirth and postpartum most participants during pregnancy attended prenatal consultations (135, 82%) with more than 4 consultations per pregnancy, however (16, 9.7%) did not carry out pregnancy surveillance and (13; 9,7%) did not carried out less than four consultations per pregnancy, as shown in table 6.

Table 6

Distribution of participants according to pregnancy surveillance

Consultation pregnancy surveillance	Freq	%
<4 consultation	13	8
> 4 consultations	135	82
Have no consultation	16	10
Total	164	100

We verified in our sample, regarding the spacing between pregnancies that (141; 78%), had a spacing between pregnancies that (141;78%), had a spacing of more than two years and with a spacing of less than two years (39;22%) according to table 7.

Table 7

Distribution of participants according to pregnancy spacing

Pregnancy spacing	Freq	%
< 2 years	39	22
> 2 years	141	78
Total	180	100

Pathology in pregnancy Most (22; 73%) reported not having been diagnosed with any type of pathology during pregnancy, the rest (8; 27%) had pathology, according to table 8.

Table 8

Distribution of participants according to pathology during pregnancy

Pathology during pregnancy	Freq	%
Yes	8	27
No	22	73
Total	30	100

Participants who had a pathology during pregnancy, the most frequent were hypertension, hemorrhage, and anemia, all with the same percentage value (3; 27.3%), hyperemesis was diagnosed in 2 participants (18.1%), as shown in table 8.1

Table 8.1.

Distribution of participants according to the type of pathology during pregnancy

Type of pathology during pregnancy	Freq	%
Hypertension	3	27.3
Hemorrhage	3	27.3
Anemia	3	27.3
Hyperemesis	2	18.1
Total	11	100

Childbirth and Postpartum Home birth was the most frequent (111; 68%), followed by the health center (46; 28%), the rest gave birth at the reference Hospital (7; 4%), as described in the table 9.

Table 9

Distribution of participants according to place of birth.

Place of birth	Freq	%
Hospital Referral	7	4
Center Health Community	46	28
Domicile	111	68
Total	164	100

We found that the delivery was attended by health personnel in (67;41%) family, (57;35%), the delivery was attended by husband (29;1%) in which the delivery was attended by Daia a (11; 6%) by her husband. As describe in table 10.

Table 10

Distribution of participants according to who attended the childbirth.

Who attended the childbirth	Freq	%
Health personnel	67	41
Family	57	35
Husband	11	6
Daia	29	18
Total	164	100

It was found that (8; 27%) had complications during childbirth, the remain participants (22;73%) reported having no complications during childbirth, as shown in table 11.

Table 11

Distribution of participants according to complications during childbirth.

Complications during childbirth	Freq	%
Yes	8	27
No	22	73
Total	30	100

Of the 30 participants who reported complications during childbirth, the most frequent type of complication was perinatal death (3; 50%), followed by hemorrhage (2; 33%) and (1;17%) breech presentation, according to it is written in table 11.1

Table 11.1.

Distribution of participants according to the type of complications during childbirth

Type of complications during childbirth	Freq	%
Bleeding	2	33
Perinatal death	3	50
Pelvic	1	17
Total	6	100

Post childbirth

Most participants reported not having postpartum complications (25;83%), it was found that (5;17%) had complication, according table 12.

Table 12

Distribution of participants according to complications during the postpartum period

Complications during the postpartum	Freq	%
Yes	5	17
No	25	83
Total	30	100

The most frequent type of complication during the postpartum period is puerperal infection (4 ;44%), followed by retention placenta (3; 33%), and bleeding (1;11%) and with the same percentage anemia, as show in table 12.

Table 12.1

Distribution of participants according to the type of postpartum complications

Type of postpartum complications	Freq	%
Bleeding	1	11.11
Puerperal infection	4	44.44
Anemia	1	11.11
Retention placenta	3	33.33
Total	9	100

Multiparity

Multiparity factors of multiparity, most refer that it is for family (21; 70%), the rest consider it tube social and cultural (9; 30%), as shown in table 13.

Table 13

Distribution of participants according to multiparity factors

Multiparity factors	Freq	%
Familiar	21	70
Social and cultural	9	30
Total	30	100

All participants (100%) reported that they had advantages in having many children. The reasons that lead to having many children, the majority (25; 62.5%), referee to being to help the family, tube the continuation of generation (10; 33%) and to take care of parents when they are elderly (5; 17%). According to explained in table 14

Table 14

Distribution of participants according to reason for the advantages of having many children

Advantages of having many children	Freq	%
Help the family	25	62.5
Continuation of generation	10	25
Take care of parents when they are elderly	5	12.5
Total	40	100

Multiparity risks

Most participants (18 ;60%) reported having knowledge about the risks of multiparity and the rest (12; 40%) reported not having knowledge, as shown in table 15.

Table 15

Distribution of participants according to knowledge about the risk of multiparity

Knowledge about the risk of multiparity	Freq	%
Yes	18	60
No	12	40
Total	30	100

As for the knowledge reported by the participants about the risks of multiparity, the majority recognized hemorrhage (16; 53 %), followed by the greater risk of pathologies (6 ;20%) risk maternal death (4 ;13%), cord prolapse (2 ;7%) risk of anemia and varicose veins (1 ;3%) respectively, as described in table 15

Table 15

Distribution of participants according to their knowledge of the risks of multiparity

Risks of multiparity	Freq	%
Hemorrhage	16	53.3
Risk of pathologies	6	20
Risk maternal death	4	13.3
Risk anemia	1	3.3
Cord prolapses	2	6.7
Varicose veins	1	3.3
Total	30	100

Multiparity Prevention

The frequency of family planning appointments is evenly distributed across the sample, if we consider that (16; 53%) of the sample refer to attending family planning (14 ;47%) refer not attend.

Table 16

Distribution of participants according to their frequency in the family planning consultation.

Family planning consultation	Freq	%
Yes	14	47
No	16	53
Total	30	100

Of the participants who attend family planning (14; 47%) in the sample, two participants reported that they abandoned the consultation, citing the following reasons: one desire to get pregnant again, and the other due to the side effects of method (bleeding).

The remaining 12 reported that they used injectables as a method before becoming pregnant (2; 17%) with the same percentage value (2; 17%) according to the table 16.

Table 16
Distribution of participants who attended family planning, according to the method they used before becoming pregnant

Consultation the family planning	Freq	%
Yes	14	47
No	16	53
Total	30	100

In the question why they did not attend family planning, most of the participants (14; 78%) refer to the reason for not attending family planning, the family, following the secondary effects of the methods (3;17%) and the lack information (1 ;6%), as a mentioned in table 16.

Discussion

A total of 30 women participated in this study, correctly completing the questionnaire items on the health of multiparity, and these were used for the statistical analysis.

Socio-Demographic Characteristics

The average age of the participants was 34.2 years, with the youngest being 23 years old and the oldest 42 years old. The women who participated in our research are 100% Catholic. Regarding the level of education, most participants (11;37%) are illiterate. As for the average age of women at marriage, it is 17 years old and for men the average is 20 years old, the youngest participant married at 14 years old, and the oldest at 26.

In Timorese society, women who do not study get married earlier, leading to having children at a very young age, tending to have many children. This situation has a lot of impact for their children in the future, related to education and health.

Culture and religion were evidenced in several reports as a form of support to accept something new, which was not planned. It was noticed the meaning that certain religious entities have for the lives of these women and, in some cases, they end up influencing and interfering in their choices. The emergence of a new child significantly changes the routine and family life. Faith emerged to face and accept such changes (Pithily EB, at al, 2013).

Raising Awareness of the Medical Risks Associated with Multiparity

In response to the question about the risks associated with having many children, participants indicated that they recognize the risks associated with high parity. Participants can identify or mention health risks, but in this study, among thirty participants, there were no risks that they identified. This does not mean that women who have many children are not at risk.

Regarding the answer about the motivation to have many children, they responded with the following reasons:

1. Help families
2. Continuation of generations
3. Taking care of parents when they are elderly

In Timorese society, having many children is a wealth, because it is related to the Timorese culture in relation to daughters and burlesque. Children are very important to take care of parents and continue family culture.

Related results, cultural influence, fear, loneliness, and helplessness led to the idea that the more children the less likely they are to experience these feelings. Having several children close to each other makes it possible to raise them at the same time, where material resources can be reused among the other members. In the future, it may represent a source of support (Patulin, et al, 2013).

According to the same author, the family can be understood as a dynamic phenomenon permeated by the influence of values and beliefs.

The low level of education of the women studied may have interfered with their possibilities to obtain and use information about contraception and health, reducing their opportunities to enter the labor market and obtain a better income, as shown by several studies. The guarantee of higher education would facilitate access and use of more adequate contraceptive methods, contributing to the reduction of unwanted pregnancies and the risk of maternal death (Medeiros, et al, 2015).

The average number of pregnancies per participant is 7 pregnancies, ranging from a minimum of 4 to a maximum of 11 pregnancies. Among the participants, we found 164 living children, with an average of 5.5 children/participant, ranging from a minimum of 2 children to a maximum of 9 children per participant. Among 164 living children, (111; 68%) were delivered at home due to transport, socio-cultural and geographical reasons.

The decision to give birth at home means exchanging everything the health system offers that is safer and more modern in terms of hospitals for an outdated and inappropriate place to give birth, according to the opinion of most people and health professionals. Culturally, in our society, the hospital is the place of excellence for the birth of babies (Kruno, Bonilha, 2004).

Regarding prenatal consultations, most pregnant women attended more than four consultations, and we found that there are still participants who do not monitor the pregnancy. That is, there are pregnant women who are still unaware of the importance of prenatal care. As for the interval between pregnancies, most of the 30 participants reported that they occurred with an interval of more than 2 years (141; 78%); with less than 2 years of spacing between pregnancies (39; 22%).

In activities related to prenatal care, studies demonstrated by researchers report that the Nursing Consultation has undergone transformations in its conception, methodology and, mainly, its insertion in health services, moving towards the prestige and acceptance of professional nurses in their work and watch (Araújo, 2007).

Preconception care is part of providing primary care in reproductive health; although they preferentially target women who wish to become pregnant, they must cover all women of childbearing age, which implies asking them about the use of contraceptive methods and about their plans with regard to a future pregnancy; identify risks, initiate appropriate intervention, and also emphasize the importance of planned pregnancies, value the first weeks of pregnancy and the need for special care, even before conception (Director Geral de Saudi, 2006).

Regarding childbirth care, most participants reported childbirth assisted by health personnel (67;41%), and childbirth assisted by Deia only (29; 18%). As for complications during childbirth, the participants reported having no complications.

The type of complication during the postpartum period is puerperal infection (4; 44%), followed by retained placenta (3; 33%). Related to the knowledge about the risks of multiparity, the participants recognized the hemorrhage (16; 53%). This study found puerperal infection (4; 44%), this because most pregnant women give birth at home and are helped by the family. Furthermore, the materials (delivery kit) they use to cut the baby's umbilical cord are not sterilized.

According to Gonzales (2003), quoted by Gomes. Montebello. (2010 p: 25), "the materials needed to carry out a delivery are: operating table with leggings, spotlight, accessory table, cabinets with obstetric material, blood pressure device, aspirator, tray, a delivery package (four fields and an apron), swabs, sterile gloves, syringe and needle, scalpel and blade, a normal delivery box, antiseptic solution, suture threads, anesthetic for episiotomy. In home birth there is not a great structure, since the essence of the birth is normal, with the least possible interventions, letting nature itself act. The assistance provided, according to the nurse, assists the newborn, providing the first care, observing vital signs, weight and height, coloration, reflection, and the birth certificate.

Family Planning is a pregnancy spacing program. This survey found (16; 53%) are not using any contraceptive method because of family factors. It refers to customs in East Timor, because most Timorese consider that the use of contraceptive methods is violating the cultural, culturally they have the principle that getting married is to have many children. Of the Participants who attend Family Planning (14; 47%), the methods they use is the injection method, because it is easy to access. Women are afraid to use other methods or still believe rumors that circulate in the community, such as rumors that say that the use of Implant and IUD should not do heavy lifting.

Regarding the risks associated with multiparity, the reasons given by the women who believed that they exist were mainly in the socio-cultural and economic sphere, the high cost of living and the inability to care for and teach their children. This is surprising as multiparity on its own is often associated with the low socio-economic background prevalent in the less developed nations of the world such as ours.

Participants' identification of risk factors was significantly related to educational status and age, and we know that knowledge increases with age. This would tend to suggest that the respondents did not benefit from adequate health knowledge during the

prenatal period about the risks of multiparity. It is important to make use of greater contact with health personnel during the prenatal period to sensitize women about the risks of multiparity and, subsequently, leave them to make their choices for family planning, presenting, and explaining each method available. so, products should be made available to help women make informed choices about their fertility.

Conclusion

Although women at the Anaro District Health Center are aware that there are dangers associated with high parity, the study reveals that they are generally unaware of these dangers. It is important to utilize the antenatal period and women's contact with health personnel to provide adequate information about the risks of multiparity, with the aim of helping women to make informed choices regarding their fertility.

In this study, all Participants said that having many children has many advantages. Referring that the motivation to have them is closely related to what is expected of a child, namely helping families, taking care of parents when they are elderly and the continuation of generations. In Timorese society, having many children is a wealth, because it is associated with burlesque in relation to daughters. Children are very important to take care of their parents and continue the family culture.

The participants were able to identify or mention the health risks related to multiparity, however in this study we did not verify their existence. The midwife's intervention is very important to prevent multiparity, clarifying the population about the risks at all levels; health, social, cultural, and educational so that couples make decisions based on knowledge and scientific evidence to enable the freedom of choice and responsible for a future of children with more education and knowledge. Its intervention also in terms of identifying risk pregnancies related to multiparity and knowing how to act appropriately, as well as promoting childbirth with health professionals, whether in health centers or hospitals or even in some situations at home depending on the geographic location and the ease of means of transport.

We hope that this research can provide the development and dynamics of nursing science, especially factors associated with multiparity and midwifery intervention.

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