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Traditional Birth Attendant in the Maternal and Child Health Space in Nigeria: Ancient Practices and Modern Recommendations

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ABSTRACT

Background: Arguments on the usefulness of Traditional Birth Attendants (TBAs) in maternal and child health care and the reduction of maternal and child morbidity and mortality indices or not, persist. This paper sought to explore the ancient practices of TBAs and to strike a balance to portray modern recommendations that would contribute to improved maternal and child health status.

Methods: The method used was review of relevant literatures from open-access journals and google scholar data base, as well as research reports on variables of the subject in developing countries.

Results: Findings revealed that the overlapping root of TBAs' practice burden include poor social amenities, inadequate health facilities and services in rural areas where over 70% of the population reside. While evidence-based report showed that even when 93% of rural women registered for Ante-Natal Care, 49% were delivered at home by TBAs and 73% has sought help from them for retained placenta with bleeding. Also, 41% of women of child bearing age indicated that maternal and child infection is a risk associated with the patronage of TBAs, whereas 32.8% indicated that bleeding during and after delivery were equally risks associated with TBA-provided maternal health services. Such circumstances of service were associated with harmful practices with attendant health and medical complications to recipient mother and child. However, helpful ancient practices of TBAs include; home visiting to promote well-being of mother and child (9.84%), sitz bath (17.20%), encouraging breastfeeding up to 2years (18.90%) etc. The modern recommendations, x-rayed the remedial actions on the harmful practices and associated negative consequences to improving maternal and child health indices in Nigeria.

Conclusion: For reasonable and sustainable reduction in the burden associated with the practices of TBAs in maternal and child health care in Nigeria, contextual focused training and continuous mentoring is a necessity.

Keywords

Traditional Birth Attendant, Ancient Practices, Maternal and Child Healthcare, Modern Recommendations, Overlapping, Evidence-Based Burden.

Introduction

A Traditional Birth Attendant (TBA) is a person who assists the mother during childbirth and who actually acquired her skills by delivering babies herself or by working with other TBAs [1]. Arguments for and against TBAs in maternal health care globally heightened with the advent of Safe Motherhood Initiative in 1987 and the attendant policy shift as well as sectorial contextual reviews [2].

Traditional Birth Attendants provide basic healthcare, support and advice during and after pregnancy as well as childbirth based on primary experience and knowledge acquired informally through the traditional practices of the community where they originate. They usually work in rural, remote and other medically underserved areas.

The origin and initiation of TBA is traced to the pre-conventional medicine era, wherein child delivery was associated with mother-in-law, mother, aunt or sister-in-law [3]. Child's birth is being seen as an important socio-demographic and cultural event in families and communities with great joy and hope attached to it (see figure 1). Studies indicated that TBAs were initiated through apprenticeship from family members who were TBAs and other non-family TBAs, including dreams and revelations [4].



Baby in womb models, Poggi Museum Bologna, Italy - Images S. Deepak

Figure 1: Model of Baby in the Uterus.

With the advent of conventional medicine during the colonial period, particularly in Nigeria, modern health services were gradually introduced in rural and urban communities and more so after independence via several development plans. Nevertheless, TBAs' practices in Maternal and Child Health care, persist and raising a lot of questions within the Public Health space.

Our concern as a health system towards TBA is the fact that, delivery practices are important predictor of birth outcome (from the onset of conception to the time of delivery and during post-

partum period for both mother and baby). Therefore, the need for an holistic view of the practices among other cross-cutting variables.

Aim of the Paper

This paper aims to explore the ancient practices of TBAs and to strike a balance to portray modern recommendations that would contribute to improved maternal and child health indices in Nigeria.

Methodology

The method used was review of relevant evidence-based literature from open-access journals and google scholar data base, as well as research reports on variables of the subject in Nigeria and other developing countries in the globe.

The Burden Associated with Traditional Birth Attendants (TBAs)

Maternal and child health (MCH) care is the services provided to mothers (women in their child bearing age) and children. The targets for MCH services, transcend women of 15-49years as child bearing age, children, school age population and adolescents, with the key objectives to reduce maternal morbidity and mortality; perinatal and neonatal morbidity and mortality amongst others. The major complications that account for nearly 75% of all maternal deaths are severe bleeding (mostly bleeding after childbirth); infections (usually after childbirth); high blood pressure during pregnancy (pre-eclampsia and eclampsia) [5].

In the continuum of maternal health care, ANC and institutional/skilled attendance at delivery and Post-Natal Care are important milestones required to achieve optimum maternal and child health [6]. Furthermore, in recognition of the potential of care during the antenatal period to improve a range of health outcomes for women and children, the World Summit for children in 1990 adopted ANC as a specific goal, "Access by all pregnant women to prenatal care, trained attendants during childbirth and referral facilities for high-risk pregnancies and obstetric emergencies" among other such Conferences. Access is a multi-dimensional concept that is very difficult to monitor. Most contributors, recognized at least five different components of access, including physical availability of services, distance and/or time to a facility, economic and other costs associated with uptake of services, cultural and social factors that may impede access and quality of services offered [7].

The accessibility of TBA-provided maternal health care is not an end in itself but a response to a failed modern maternal health care system in Nigeria. Access and utilization of quality health is debatable as a result of a weak Primary Health Care System coupled with constrained health resources [8]. It is mind aching that, the overlapping root of TBAs' Practice Burden, is characterized by a fundamental estimate of 60-80% of all deliveries in developing countries, occurring outside health care facilities with significant proportion of these attended by TBAs [9], borne out of inherent attributable factors. Nigeria as a country with about 200 million projected population based on the 2006 census has about 70%

of the population residing in the rural areas. These areas lack the basic amenities of life, good road network, portable drinking water, adequate health facilities etc. The inadequacy of health care facilities and services propagates the existence of TBAs [8].

In a qualitative cross-sectional study of 122 women of child bearing age in Ogu, Ogu/Bolo LGA in Rivers State, in the South-South, Nigeria, 41% of the respondents stated that maternal and child infection is one of the risks associated with the patronage of TBAs, while 32.8% indicated that bleeding during and after delivery were risks associated with the patronage of TBA-provided maternal health services [10]. Earlier, an Eastern Nigeria study showed that even when 93% of rural women registered for ANC, 49% were delivered at home by TBAs [11].

In Niger State, in North Central Nigeria, 84% of households interviewed utilize the services of TBAs or village health workers and that the TBAs have also been shown to exist in urban areas [12]. While, in a study of 377 women who delivered before arrival at the hospital in Ogbomosho, South Western Nigeria, revealed that 65% of the mothers were delivered by TBAs, while 73% has sought help from them for retained placenta with bleeding [13]. The situation of these burden may not be different in the other remaining two zones – North West and North East, in Nigeria.

The report of [14] estimates maternal mortality ratio and pregnancy-related mortality ratio at 512 per 100,000 live births and 566 per 100,000 live births respectively. The report further stated that only 39% of women delivered their last live birth in a health facility, of these, 26% deliveries were in public facilities and 13% in private facilities, while 59% delivered at home. The report also indicated that whereas, 61% urban births were in a health facility against 26% rural births. The Sustainable Development Goal (SDG) 3.1 target is to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030, meaning Nigeria should have same focus in that perspective. It is quite obvious that fragile settings which are known to be associated more with the rural communities are where about half of the key targets of the SDGs, including Child and Maternal Health, remain unmet.

The Ancient Practices of TBAS

According to [15], one of the harmful traditional practices in Northern Nigeria, is the subsection of a pregnant woman to “Gishiri Cut” or “Yanka Gishiri”. This is a traditional surgical cut on any aspect of the vaginal wall, usually the anterior wall using razor blade or knife by the TBAs, mainly in the first delivery as a remedy to obstructed labour. The associated complications were severe bleeding leading to shock (See Fig. 2), excruciating pain, vesico-vaginal fistula, HIV, and painful intercourse later.

In the study of [17], a TBA in Idah, Kogi State, Nigeria, reported her practices as thus: “when a woman is in labour, I take her to the back of my house where I have a plantain farm”. “The woman would sit on a log facing the river where her blood will be flushed during delivery. Further, I will start some incantations when the

baby is ready to come out, I will cut the leave of the plantain and keep them on the floor, to keep the baby when delivered”. “I would then dig a small hole in the ground where I will bury the placenta”. When there are some complications, she make a drink from some local herbs and gives to the mother. Thereafter, she gently pushes a stick into the woman’s mouth, three times. On the third push, she claims that the woman will deliver her baby naturally.

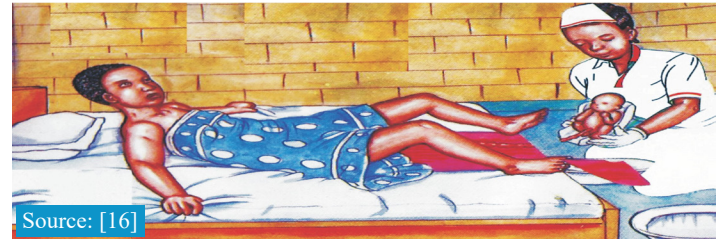


Figure 2: Severe bleeding after delivery of baby.

In same study of [17], a TBA in Anambra State, South Eastern Nigeria on successful delivery, cuts off the placenta with a razor (See Figures. 3 & 4), massages the mother using herbs. She then gives her a herbal drink which she says helps the body to heal quickly.

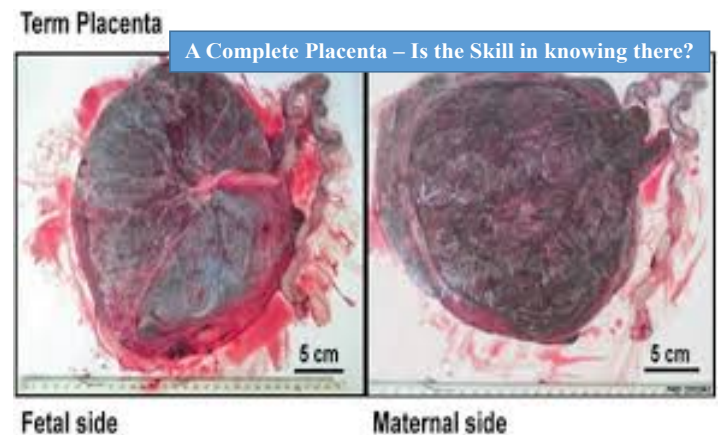


Figure 3: Complete placenta at term.



Figure 4: Incomplete placenta.

Poor Skills in performing the External cephalic maneuver may lead to – premature separation of the placenta; ante-partum haemorrhage; intrauterine fetal death etc.



First maneuver:
The superior surface of the fundus is palpated to determine consistency, shape, and mobility.



Second maneuver:
Both sides of the uterus are palpated to determine the direction the fetal back is facing.



Third maneuver:
This step determines the part of the fetus at the inlet and its mobility.



Fourth maneuver:
This step determines the fetal attitude and degree of fetal extension into the pelvis.

Anterolateral view of a health care worker performing the Leopold maneuvers on a pregnant woman and fetus. The purpose is to systematically observe and palpate the abdomen to determine fetal presentation and position.

LWWAT Collection Images Copyright © 1989-2001 by Lippincott, Williams & Wilkins, Baltimore, MD

Figure 5: External cephalic maneuver.

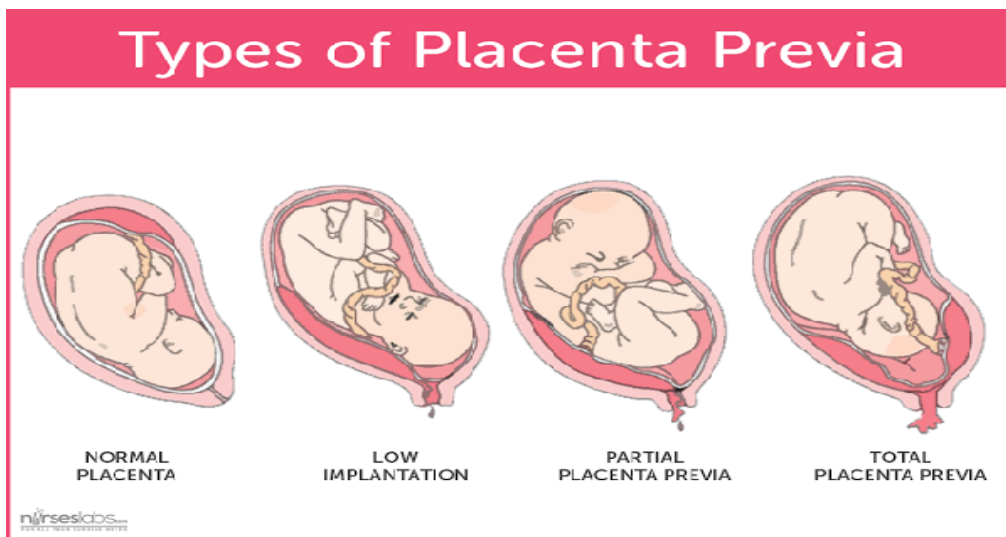


Figure 6: Types of Placenta Previa.

Other notable general harmful practices of TBAs include: Delivery of baby on dirty surfaces, Lack of recommended hand washing skills, Guarding the perineum with foot, Frequent vaginal examination (V.E), Application of pressure on the abdomen with hand, knee, stool or other object to stop bleeding etc. [18,19].

In the earlier work of [20], TBAs engage in some practices, negatively affecting the mother and baby including: External cephalic maneuver (See Figure 5), Inappropriate cutting and management of the umbilical cord using bamboo barks, dirty knives, old razor blades or pieces of broken bottles, Use of herbs to facilitate cervical dilatation, Cultural practices hovering around female genital mutilation, Crude fertility control, Crude termination of Pregnancy. The concern is that all of these have attendant complications in terms of morbidity and even death, but persist.

More so, it is estimated that 4 per 1000 births come with placenta previa (See fig. 6) and associated post partum haemorrhage [21,22]. Meaning in Nigeria, about 40, 000 births are associated with placenta previa which magnitude varies across the geopolitical zones, and noting that majority of the births are conducted by TBAs. This condition required no Vaginal Examination during labour, which knowledge is lacking among TBAs, else increases the risk of intra and post partum haemorrhage and associated maternal and fetal death. Nevertheless, according to [1], some positive practices of TBA include: Home visiting to promote the well-being of mother and child, Encouraging breastfeeding up to 2years that also enhances fertility control, Encouraging Sitz bath morning and evening to enhance complete emptying of the product of conception in the uterus, Helping in bathing mothers and babies most times as well as in some domestic work until mother is strong enough to help herself and baby, Use of palliative dialect and language in making mothers feel at home. Furthermore, figure 7 indicated helpful ancient practices of TBAs including; home visiting to promote well-being of mother and child (9.84%), sitz bath (17.20%), encouraging breastfeeding up to 2years (18.90%), psychological support (13.9%), bathing of mother and baby (7.3%) [10].

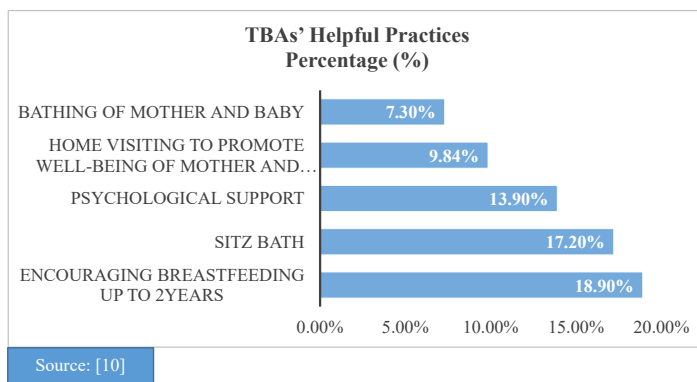


Figure 7: TBAs' Helpful Practices.

Modern Recommendations for TBA

The forerunner to the modern recommendations should be:

1. Mapping of TBAs based on socio-demographic, socio-economic and geographical variables for quick appraisal of areas of concentration of high volume home delivery.
2. In-depth qualitative assessment of practices of TBAs regarding Maternal and Child Health situations in culturally acceptable procedures based on outcome of mapping on attributes of TBAs.
3. Determination of contextual scope of training and methodology to be applied.
4. The understanding of the health system in Nigeria towards putting in place workable strategies around the justiciable right of choice or preference for care that commands satisfaction on issues of Maternal and Child Health Care, noting that, in most African communities, Maternal Health Care services co-exists with traditional health care services, therefore women must choose between these options and individual perception of the efficiency and effectiveness (satisfaction) of modern health services and religious belief also play a significant role.

Therefore, the TBA should be trained on:

1. Basic infection control skills, such as hand washing with soap and running water, clean surfaces and environment for delivery and care for mother and child etc.
2. Basic skills in cultural context for identification of danger signs in pregnancy and referral.
3. Basic skills in counselling on Reproductive Health and Safe Motherhood Initiative including Referral for Immediate Post-Partum Family Planning.
4. Assigning specific number of TBAs to Junior Community Health Extension Workers (JCHEWs) for continuous mentoring, monitoring and supervision and linkage with the health system.
5. Working out feasible and sustainable economic and social reward system for TBAs based on number of linked cases for maternal and child health care in the health facility.

It is important to mention that these procedural recommendations has been piloted reasonably in Community-Focused Approach to Post-pregnancy Family Planning programme (PoPCare project) aimed at, increase uptake of modern contraception and post-abortion care among young first-time parents under the age of 24 years delivering outside of health facilities in three states in Nigeria, namely Lagos, Nasarawa and Rivers from (2018-2022) by Clinton Health Access Initiative (CHAI) in collaboration with Federal Ministry of Health and the respective State Ministry of Health.

For instance in Rivers State, the PoPCare Project was implemented in 4 pilot Local Government Areas: Akuku-Toru, Asari-Toru, Degema, and Ogu/Bolo. The success story is better spoken from the evidence-based testimonies from beneficiaries, being result of a qualitative study, as thus: "The storyteller is a married 26-year old young first-time mother (YFTM) with a child and living with her husband. She plans to have four more children in the future. She participated in all PoPCare activities for YFTMs except talking to a Community Reproductive Health Influencer (CRHI/TBA). She described her increased awareness about family planning as an

important change. She was counseled about family planning in the hospital after giving birth but did not take-up a method. Later, she was counseled again through door-to-door education and chose to get an implant. In-between her counseling in the hospital and at home, she discussed her desire for the implant with her husband and obtained information that dispelled her fears about side effects. She further stated that getting the implant aided her prevent pregnancy soon after childbirth, kept her healthy, allowed her to continue her business endeavours and gave her time to raise her son. She plans to teach him about family planning in the future.”

Let us get the valued outcomes of the testimony from the CHRI, Health Care Worker and Society for Gynecologists and Obstetricians (SGO) based on the qualitative study:

“If the PopCare people did not come and begin to walk from door-to-door, she would have been giving birth anyhow. As they came, she had already heard from the health worker before and as she heard from them again, she changed her mind and decided to try” - CHRI from Rivers State in [23].

“More of the door-to-door awareness was what made her to really make up her mind. So, the door-to-door awareness should be ongoing because some maybe aware, or maybe they are on the line, but when you go door-to-door you do as if evangelizing it. You are able to talk to them and they will now make up their mind to take a method.” - Health Care Worker from Rivers State in [23].

“She is young, she went to the hospital, she was counseled in the hospital she did not make up her mind, she went home, there was community engagement where she got to hear again, this one answers the question that we should not give up even when some people don't get to hear of it. I mean don't accept it, if you [provider] are told 'No' we should continue the house-to-house awareness campaign. She discussed it with her partner, got the partners' consent, she is even planning to pass the information to the next generation.” - SGO from Rivers State in [23].

“...She is not just talking about herself now but her child and the future. So, that is the continuation, passing it from one generation to the other, that is likely to solve any mistake that may arise. Or at least if the son gets all these information, he can really influence his peers...the information is at his disposal.” - SGO from Rivers State in [23].

In all of these, the stories of change as testimonies of PoPCare project's benefits include; increased referral and delivery in the health facility to prevent maternal death, improved reputation of CRHIs/TBAs in the community and with health care workers, increased demand and uptake of family planning by YFTM, decreased family planning misconceptions among YFTM [23].

Conclusion

Working around the modern recommendations as provided, among other policy thrust will go a long way in achieving reasonable and sustainable reduction in the burden associated with the practices of

the TBA in maternal and child health care in Nigeria and indeed other developing countries, which will translate to improving maternal and child health indices globally.

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