

Traditional Birth Attendants Issue: a Menace in Developing Countries**BUOWARI OY, MBBS**

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ABSTRACT

BACKGROUND: A significant proportion of births in Nigeria still occur at homes of traditional birth attendant. Traditional birth attendants are popular in developing and low resource countries. They lack no formal education or medical training and their clients end up with obstetric complications which lead to severe morbidity and mortality.

CASE SUMMARY: Two cases of pregnant women that engaged the services of traditional birth attendants (TBA) before presenting at a health facility are presented. They ended up with severe morbidity and mortalities. A 29 year old gravida 3 + para 2+0 woman with two previous caesarean section(C/S) was counselled for elective c/s but declined. She presented at the home of a TBA, had spontaneous vagina deliver, collapsed one hour after delivery and was dead by the time she was brought to the hospital. A 30 year old gravida 10 para 7 + 3 presented in hospital after being in labour at the home of a TBA for three days. On presentation in hospital there was absent foetal heart sound. At surgery there was ruptured uterus and subtotal hysterectomy was done.

CONCLUSION: To improve the situation better access to optimal antenatal care and intrapartum care together with early referral of high-risk patients must be facilitated. Increased community awareness, promotion of appropriate technology for effective health care planning strategy from the grassroots level to tertiary centres is important in the reduction of obstructed labour. One of the most effective means of reducing maternal mortality is the provision of caesarean section for all women who need it.

KEY WORDS: Maternal, Morbidity, Ruptured, Elampsia

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INTRODUCTION

The vast majority of neonatal deaths and maternal deaths occur in developing countries, traditional birth attendants (TBA) attend to 43% of births in developing countries, the proportion generally being higher in rural areas with most of these deliveries taking place at home¹. Of the approximately four million global neonatal deaths that occur annually, 98% occur in developing countries where most newborns die at home while mothers, relatives, and TBAs care for them¹. Significant number of deliveries in the developing world takes place at home mostly conducted by TBAs. Some of their practices are harmful and contribute significantly to morbidity and mortality

especially if untrained². TBAs are women who administer antenatal care, conduct deliveries, and look after the mother and child in the postpartum period. Recent studies have revealed many complicated cases of obstructed labour from TBA³. TBAs also known as the traditional midwife is a primary pregnancy and child care provider. They provide the majority of primary maternity care in developing countries and may function within specific communities.

The focus of their work is usually assisting women during childbirth delivery and in the immediate postpartum period. Frequently their assistance includes helping with household chores. Most TBAs travel to the pregnant woman's house to provide care, women may also travel to them to obtain care. The TBAs acquire their skills by delivering babies themselves or through apprenticeship to other TBAs. The TBAs conduct deliveries in the villages. Their experiences and background vary considerably.

They are the people who are known for delivery in their communities. They may be old or young usually they have no formal education and are usually well respected in their societies. In most developing countries, the TBAs are frequently older women, often illiterate. Some assist with a small number of deliveries per year, others do with frequent deliveries. Generally, they are culturally inclined. Their existence is as old as the existence of man on earth. Women in the developing world are forty times more likely to die from pregnancy related complications than women living in the industrial world.

Since the adoption of the primary health care (PHC) approach in 1979, government has recognised the need for integrating TBAs into the PHC system and had consequently initiated TBAs training programmes⁴.

Many programmes have been initiated by various organizations and agencies including the World Health Organization (WHO) for training of TBAs between the 1970s and 1990s⁵. It is often assumed that with trained TBAs, there will be a reduction both in maternal and neonatal morbidity and in mortality. The TBAs need to be trained, as this will empower them to identify problems and refer them appropriately. The rationale for such programmes has been the assumption that TBAs are present at home deliveries and can be trained to avoid harmful delivery and postnatal practices and TBAs can be trained to recognise complications in the mother and newborn and make adequate referrals⁶.

TBAs inherit their trade from mothers, senior female family members, and ancestors. The TBAs are very cheap in charges. One wonders if they do not take more deliveries that even some obstetricians do and of course with more complications. General Hospital Aliero does not have an active obstetric team. At the time the cases were managed, the hospital was managed by doctors with no specialty postgraduate training in obstetrics but general practitioners with the bachelor of medicine and surgery degree. I present cases of two parturient managed at General Hospital, Aliero, Nigeria from February to December 2006 who visited the TBAs and had severe morbidity and mortalities. General hospital, Aliero is a general hospital located in northern Nigeria.

CASE 1

A 29 year old gravida 3 Para 2⁺⁰ woman was counselled for elective caesarean section at term because she has had two previous caesarean sections in her previous deliveries. She had two previous emergency caesarean section for cephalopelvic disproportion and was advised at the hospital of her last confinement to register for antenatal care and deliver in her health facility in a hospital. She declined that all her peers had spontaneous vagina delivery.

She presented at the home of a traditional birth attendant when she went into spontaneous labour. One hour after delivering vaginally, she collapsed in a pool of blood at the home of the traditional birth attendant with clots of blood gushing out of her vagina. She was then rushed to a health facility by which time there was no cardiac and respiratory activity. None of her relatives could give information on what was done to her by the traditional birth attendant and patient was dead so could not give any history.

CASE 2

A 30-year-old gravida 10 Para 7⁺² presented after visiting a TBA's place for three days at an unknown gestation. Her pregnancy was not supervised. Her sixth and seventh confinements were intrauterine foetal deaths. She was conscious, pale, in painful distress, pulse rate 112 bpm, and blood pressure 80/50 mmhg. There was generalized abdominal tenderness; foetal heart was not heard and easily palpable foetal parts. A diagnosis of a multipara with ruptured uterus following prolonged obstructed labour, intrauterine foetal death and hypovolaemic shock was made. She was resuscitated and surgery planned. Intra-abdominal findings were haemoperitoneum of 1.5L of blood, macerated stillbirth in the peritoneal cavity and longitudinal uterine rupture in the lower segment anterior with ragged necrotic edges extending to the upper segment with 20cm in length. Birth weight was 4.3kg and estimated blood loss was 2.5 L. Subtotal hysterectomy was done.

DISCUSSION

In developing countries transportation difficulties and poor obstetric services are causes of maternal morbidity and mortality. The mortality in case 1 probably resulted from uterine rupture and severe haemorrhage since the patient has had two previous scars on her uterus. The second patient may have had her uterus repaired instead of it been removed if had presented early at a health facility.

Evidence from numerous studies has shown reduced maternal and perinatal morbidity and mortality when women have a qualified health care provider who has midwifery or obstetric skills present at every birth. TBAs speak the local languages; allow traditional birthing practices and respect of the community and flexible modes of payment. Problems can arise, however when TBAs delay seeking skilled care for women in difficult labour.

Trained TBAs are more knowledgeable on danger signs during pregnancy and child health and are more likely to refer women with complication to a health facility compared to untrained TBAs. TBAs should be trained on early identification of mothers with obstetrical complications and on prompt referral to health facilities that can provide emergency obstetric care⁷. They should focus solely on training component and should induce adequate supervision, transportation and provision of supplies in particular TBA programmes should increase efforts to ensure the availability of supplies to conduct a clean delivery since this is essential for TBAs to follow aseptic procedures. Over the past decade, TBAs in many regions have been trained in midwifery and basic hygiene as part of a safe motherhood initiative aimed at reducing maternal mortality⁸. Although providing highly skilled medical attendants for all deliveries in poor communities remain a long-term goal, an intermediate solution is to identify, support, and train birth attendants who are already practising in local communities⁹.

Neglected labour is a common cause of maternal and perinatal morbidity and mortality in developing countries¹⁰. Advanced obstructed labour is probably the leading cause of maternal and perinatal mortality in the West African sub region.

Postpartum haemorrhage is one the top five causes of maternal mortality in both developed and developing countries. Obstetric haemorrhage is the world's leading cause of maternal mortality. Postpartum haemorrhage is the most common type of obstetric haemorrhage and accounts for the majority of cases that occur each year. To tackle and prevent the morbidity and mortality associated with postpartum haemorrhage there is need to anticipate it and actively manage the third stage of labour.

CONCLUSION

Community based interventions are required to improve the number of families engaging a skilled attendant and hygiene during delivery. Health education of the populace on the importance of antenatal care, improvement in the socio-economic conditions, female education, and proper supervision during labour and provision of adequate and accessible facilities with proper referral services are some of the ways of preventing and reducing maternal morbidity and mortality. When the women and their families know the importance of antenatal care they will not engage the services TBAs but present in hospital when in labour and accept the counsel of the medical personnel. In some African communities women delivering by c/s are seen as not woman enough and not strong enough. Education of the populace will disabuse their minds against it and not abuse or laugh at women who had c/s.

Women continue to die in childbirth because they do not gain access to essential obstetric care when available various cultural and traditional beliefs make them not to utilise such services even it is subsidized or even made free by the some state and governments of some countries. This will go a long way of lowering the high maternal and neonatal mortality with subsequent lowering of perinatal mortality rates. Maternal mortality is very high in some under resourced settings.

Every pregnant woman needs access to facilities with capabilities to provide emergency obstetric care. Transportation to an appropriate health facility was a major problem in the two cases discussed. Impact of effective and efficient emergency obstetric care as part of the strategy of safe motherhood in reducing maternal deaths in the practice cannot be overemphasized.

REFERENCE

1. Alexandre B et al. Caesarean Section Rate for Maternal Indication in Sub-Saharan Africa: A Systematic Review. *The Lancet*. 358(9290): 1328-1333
2. Goodburn et al. Training Traditional Birth Attendants In Clean Delivery Does Not Prevent Postpartum Infection. *Health, Policy, and Planning*. 15(4): 394-399
3. Ekanem AD, Mboho MM, Udoma EJ, Itima SM. Prevention Of Maternal Mortality By Training The Birth Attendants Of Church Based Maternity Homes In Akwa-Ibom State. *Trop J Obs Gynae*. 22(2): 2005. 180-183
4. Ofili AN, Okoje OH. Assessment of the Role of Traditional Birth Attendants in Maternity Health Care in Oredo Local Government Area, Edo State, Nigeria. *J Community Med PHC*. 17(1): 2005: 55-60
5. Jokhio AH, Winter AR, Cheng K. An Intervention Involving Traditional Birth Attendants and Prenatal and Maternal Mortality in Pakistan. *NEJM*. 352: 2091-2099
6. Cochrane Update. Traditional Birth Attendants Training For Improving Health Behaviours and Pregnancy Outcomes. 1110: 1017-1018
7. Hussein AK, Mpembeni R. Recognition Of High Risk Pregnancies And Referral Practices Among Traditional Birth Attendants In Mkuranga District, Coast Region, Tanzania. *Afri J Reprod Health*. 9(1): 113-122
8. Walraven G, Weeks A. The Role of Traditional Birth Attendants with Midwifery Skills in the Reduction of Maternal Mortality. *Trop Med Int Health*. 1999. 4: 527-529
9. Bulterys M Et Al. Role of Traditional Birth Attendants in Preventing Perinatal Transmission of Human Immunodeficiency Syndrome. *BMJ* 324(7331): 222-225
10. Gessesew W, Mesfin M. Obstructed Labour In Adigrat Zonal Hospital, Tigray Region, Ethiopia. *Ethiopia J Health Development*. 17(3): 175-180