CASE REPORT

From traditional birth attendants to hospital: a maternal near-miss

Ogunlaja OA[a], Fehintola AO[a], Ogunlaja IP[b], Idowu A[c], Abiola OO[d], Bojuwoye MO[e]

a. Department of Obstetrics & Gynaecology, Bowen University Teaching Hospital, Ogbomoso, Nigeria

b. Department of Obstetrics & Gynaecology, General Hospital, Ilorin, Nigeria

c. Department of Community Medicine, Bowen University Teaching Hospital, Ogbomoso, Nigeria

d. Department of Surgery, Bowen University Teaching Hospital, Ogbomoso, Nigeria

e. Gastroenterology Unit, Department of Medicine, University Ilorin Teaching Hospital, Ilorin, Nigeria

Correspondence to: Olumuyiwa A Ogunlajal lajamuyiwa@yahoo.com

Introduction

'Maternal near-miss' is defined as a woman who nearly died during pregnancy or following delivery but survived. The story of many women in sub Saharan Africa is that of an escape from death if they do eventually have a safe delivery [1]. This situation is not unconnected to several factors as it concerns these women, their families, the society and the choices they make.

Case report

A 43-year old para 5+0 (4 alive) woman presented in our hospital after a departure against medical advice from a private hospital where she had had a Caesarean section performed and subsequently developed a burst abdomen on the fifth post-operative day. This was preceded by a history of labour pains of about 48 hours in a traditional birth attendant (TBA) home where various manoeuvres were tried to facilitate the delivery of the foetus. She was however referred to the private hospital when it was observed that the foetal heart beats were not heard.

On presentation in our hospital she was acutely ill-looking, pale, jaundiced and mildly dehydrated. The pulse rate was 124 beats per minute and the blood pressure was 100/70mmHg. The respiratory rate was 40 breaths per minute and she was placed on supplemental oxygen. The abdomen was distended and the bowel sounds were hypoactive. There were copious purulent effluents from the abdominal wall wound. The devitalized uterus was seen at the base of the wound, with the wound edges showing devitalized skin, subcutaneous tissues and rectus sheath (Figure 1). Copious purulent discharge was noticed in the vagina.

She was resuscitated with intravenous fluid and intravenous antibiotics were administered. Investigation results: Packed cell volume: 27%, white blood count revealed neutrophilia. There was a mild

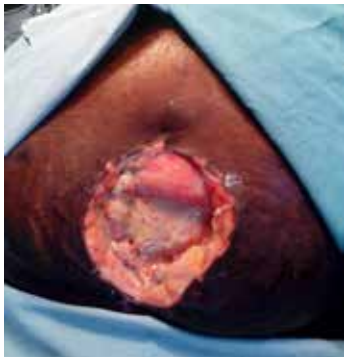

Figure 1. Devitalized uterus at the base of the wound with devitalized edges involving the skin, subcutaneous tissues and rectus sheath. (credit Ogunlaja et al)

Figure 2. During hysterectomy; the devitalized lower uterine segment with copious purulent discharge noted. (credit Ogunlaja et al)

elevation of urea, creatinine, bilirubin and alanine transaminase. A pint of blood was transfused immediately and she was prepared for wound debridement, closure and total abdominal hysterectomy. Operative findings revealed a devitalized lower uterine segment with copious purulent discharge (Figure 2).

A total abdominal hysterectomy with peritoneal lavage and toileting were carried out and the wound was closed with interrupted nylon stitches. Post operatively, she had antibiotics (amoxycillin+clavulanic acid and metronidazole), analgesics and intravenous fluids. Her post-operative recovery was satisfactory.

Discussion

Despite various programmes and strategies embarked upon in the past, Africa continues to have high maternal morbidity and mortality rates. This situation is particularly bad in the sub Saharan region [1]. Nigeria contributes about 10% to the maternal mortality figures [2]. This is due to a dearth of medical facilities, poor training and retraining of health workers and increases in deliveries conducted by TBAs [3,4]. The roles of TBAs have been the subject of debate among health professionals and several studies have been conducted to ascertain the most effective strategies [5 - 8]. An earlier study that reviewed intrapartum referrals by TBAs to a Mission Hospital in Southeastern Nigeria observed that such referrals resulted in over 60% of the maternal deaths recorded at the hospital [9].

The case presented above clearly shows the typical fate of many women of low socioeconomic status in our society. She presented first in labour to a TBA home but she was only transferred to a private hospital after observing that foetal death had occurred after about 24 hours in labour. At the private hospital she was offered a Caesarean Section despite the findings of intrauterine foetal death. She was only referred on after her wound underwent complete breakdown about fifth day post operation. It is important to state that Caesarean Section should not be the first modality of management in cases of intrauterine foetal death especially in Africa.

The need for education of girl children, women and families cannot be over emphasized as this will help in making right choices about where, when and how to get help during pregnancy or delivery irrespective of their socioeconomic situation. Effective training, engagement, monitoring and supervision of TBAs could improve maternal and newborn health in our environment.

Conclusion

Advocacy and legislation should be strengthened to ensure improved education. Policies may be put in place to encourage TBAs who refer patients to the hospital especially before the onset of complications. Collaboration between TBAs and health care workers should be encouraged.

Conflict of interest: No author has any conflict of interest to declare.
Funding: None
Ethical approval Patient's consent was obtained

References

1. Neilson JP. Traditional birth attendant training for improving health behaviours and pregnancy outcomes: Cochrane update. *Obstet Gynecol* 2007;110:1017-8.
2. Federal Ministry of Health. Maternal Mortality Situation and Determinants in Nigeria. Abuja Nigeria: Federal Ministry of Health; 2004. p. 1-10.
3. Ahmed O, Odunukwe N, Raheem Y, Efienemokwu G, Junaid M, Adesesan S, etal. Knowledge, attitude and perception of HIV/AIDS among traditional birth attendants and herbal practitioners in Lagos State, Nigeria *Afr J AIDS Res* 2004;3:191-6.
4. Imogie AO, Agwubike EO, Aluko K. Assessing the role of traditional birth attendants (TBAs) in health care delivery in Edo State, Nigeria. *Afr J Reprod Health* 2002;6:94-100.
5. Ana J. Head to Head: Are traditional birth attendants good for improving maternal and perinatal health? Yes. *British Medical Journal.* 2011;(342): d3310.
6. Sibley LM, Sipe TA & Koblinsky M. Does TBA training increase use of professional antenatal care services: a review of the evidence. *Journal of Midwifery and Women's Health.* 2004; 49(4): 298-305.
7. Darmstadt GL, Lee AC, Cousens S, Sibley L, Bhutta ZA, Donnay F et al. 60 million non-facility births: who can deliver in community settings to reduce intra-partum-related deaths? *International Journal of Gynaecology & Obstetrics.* 2009;107 (Suppl 1): S89-112.
8. Harrison KA. Head to Head: Are traditional birth attendants good for improving maternal and perinatal health? *British Medical Journal.* 2011; 342:d3308.
9. Umeora OU, Ejikeme BN, Igberase GO. Intrapartum referrals from traditional birth attendants in Southeast Nigeria: Patterns and outcoms. *Trop J Obstet Gynaecol* 2007;24:24-9.